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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1989

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

ON

H.R. 4783

AN ACT MAKING APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES, FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1989, AND FOR OTHER PURPOSES

Part 3 (Pages 1-798)

Nondepartmental witnesses

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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1989

TUESDAY, MAY 17, 1988

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:53 a.m., in room SD–138, Dirksen Senate Office Building, Hon. Lawton Chiles (chairman) presiding.

Present: Senators Chiles and Harkin.

CONGRESSIONAL WITNESSES

Senator CHILES. This morning the subcommittee will begin the first of 9 days of public witnesses with testimony focusing on programs funded by the Subcommittee on Labor, Health and Human Service, Education and the 14 related agencies.

During these several sessions, the subcommittee will hear testimony from approximately 225 witnesses, the highest number yet to be heard by the subcommittee in a single year. Because of the large number of witnesses, we must request that each witness keep their oral testimony brief. You should be assured your full statement will be included in the printed record.

In order to help us stay on schedule, we are going to use the green-red light system. When the red light goes on, your 3 minutes have expired. We will need to ask each of you to conclude your remarks when the red light goes on so that each witness will have a fair and equal opportunity to be heard.

STATEMENT OF HON. JOHN HEINZ, U.S. SENATOR FROM PENNSYLVANIA

Senator CHILES. Our first witness will be Senator Heinz. We are delighted to have the Senator from Pennsylvania with us this morning.

Senator HEINZ. Mr. Chairman, thank you very much. It is a great pleasure to be here. I appreciate the opportunity to testify most specifically on the Low Income Energy Assistance Program, or LIHEAP as we often refer to it.

I have a written statement which I would like to submit for the record, and I would like to summarize its more salient points.

Senator CHILES. Your statement in full will be included in the record, Senator.

Senator **Heinz.** Mr. Chairman, the Low Income Energy Assistance Program, as I think you know, is a critically important safety net that helps the poor pay their utility bills. Federal funding for that program peaked back in 1985 at some $2.1 billion. Since then, Congress has reduced funding for the program by 27 percent to $1.5 billion.

The President's fiscal year 1989 proposal would fund that program at $1.2 billion, an amount 26 percent lower than the fiscal year 1980 appropriation for a predecessor program.

Because of the steady erosion in Federal support for the program, therefore, benefits reached just 6.7 million households or fewer than 30 percent of the 23.4 million federally eligible households.

Mr. Chairman, I cannot overemphasize the fact that the Low Income Energy Assistance Program serves only the truly needy. It serves women who are poor and who have children, the elderly on fixed incomes, many households headed by or containing handicapped persons, the working poor; some who are in the grips of seemingly permanent poverty; others are faced with a temporary but nonetheless severe need for help in meeting budgets.

According to a study prepared for the National Association of State Community Service Programs, households eligible for LIHEAP benefits had a mean household income of $6,184, less than one-quarter the national average of per-household of some $25,194.

The typical Low Income Energy Assistance Program household spent about 44 percent of its income, nearly $2,700 a year, on housing; 35 percent or not quite $2,200 per year on food; 15 percent or about $940 per year on home energy, about four times the national average; leaving only about 6 percent or $355 a year for all other discretionary purposes.

Some $355 a year, Mr. Chairman, is $30 per month for a household for everything else except food, housing, and energy. That has to pay for transportation, has to pay for clothing, has to pay for medication, health care, out-of-pocket expenses, not to mention maybe going to a movie if that would ever be possible.

The low income energy assistance benefit is about $213, the national average that year, and it boosted that discretionary income, if you will, by the equivalent of some 60 percent for those households fortunate enough to receive funds.

PREPARED STATEMENT

Mr. Chairman, I would like to share with the subcommittee a report recently published by the Northeast Midwest Institute entitled "Narrowing the Gap, the Energy Needs of the Poor and Federal Funding." It shows rather clearly on the cover what has happened to low income energy assistance support. I commend this program to the committee and ask that it be a part of your hearing record.

[The statement follows:]

STATEMENT OF SENATOR JOHN HEINZ

Good morning, Mr. Chairman. I appreciate the opportunity to testify on the Low Income Home Energy Assistance Program (LIHEAP).

LIHEAP is a critically important "safety-net" program that helps the poor pay their utility bills. The premise behind LIHEAP is that the poor should have access to basic utility service. During the 1970s and early 1980s, energy price increases due to geopolitical events and deregulation seriously restricted that access.

Federal funding for LIHEAP peaked at $2.1 billion in fiscal 1985. Since then, Congress has reduced funding for the program by 27 percent, to $1.5 billion. The President proposed to cut LIHEAP even further in fiscal 1989, to $1.2 billion -- an amount 26 percent lower than the fiscal 1980 appropriation for a predecessor program. Because of the steady erosion in federal support for the program, LIHEAP benefits reach just 6.7 million households, fewer than 30 percent of the 23.4 million federally eligible households.

The House and Senate fiscal 1989 budget resolutions earmark $1.6 billion for LIHEAP. Such an amount represents a modest (4 percent) increase over current spending. But it comes on the heels of last year's 16 percent reduction. At an absolute minimum, I urge the Subcommittee to appropriate at least the amount provided for in the budget resolution. I am well aware of the spending constraints we face. But I would urge the Subcommittee to consider restoring even more of last year's cut. For the past three years, LIHEAP has shouldered a disproportionate share of federal budget deficit reduction.

Mr. Chairman, the need for LIHEAP remains unabated. Simply stated, energy costs became a significant -- and in some instances unbearable -- burden for the low income household. Even today, for many impoverished families, the combination of personal income and assistance payments simply is not enough to ensure a minimal standard of living.

Who are these families, and what are their energy costs?

Mr. Chairman, LIHEAP recipients are not "deadbeats". They are unwed mothers. Or the elderly, living on fixed incomes. Many LIHEAP households are headed by or contain handicapped persons. Most contain children. Many households are the working poor. Some are in the grip of seemingly permanent poverty. Others are experiencing a temporary but severe difficulty in meeting their budgets. Regardless of the individual circumstances, when incomes are at or below the poverty level (about $11,000 for a family of four), bills go unpaid. In some instances, families become homeless.

A 1986 study prepared for the National Association for State Community Services Programs (NASCSP) reports that in 1984, 23.4 million households were eligible for energy assistance under Federal income guidelines. The average household had an income of $25,194 that year. The LIHEAP eligible household had an income of $7,239. Under more restrictive State standards, which are permitted by law, the 17.6 million eligible households had a mean income of $6,184 -- less than one-quarter of the national average. These households devote some fifteen percent of their budgets to residential energy costs -- nearly four times the national average.

LIHEAP is vitally important to those families and individuals fortunate enough to receive benefits. For instance, the average recipient household spends all but 6 percent of its income on housing, home energy, and food. In 1984, the LIHEAP household spent:

- 44 percent of tis income ($2,692) on housing;
- 35 percent ($2,192) on food;
- 15 percent ($942) on home energy; leaving only
- 6 percent ($355 for all discretionary expenses.

Imagine having just $30 a month for *all* discretionary expenses! Just $30 per month for everything else one needs to buy ... from clothing to transportation ... school supplies or eyeglasses or medicine. A LIHEAP benefit of $213 (the national average for that year) boosted discretionary income by 60 percent.

The Northeast-Midwest Institute recently released a report entitled *Narrowing the Gap: The Energy Needs of the Poor and Federal Funding*. The report states that in 1980, federal energy assistance covered roughly 40 percent of eligible households' heating and cooling costs, estimated at $3.35 billion. For the current fiscal year, LIHEAP benefits will defray just 12.7 percent of those costs, estimated at $9.35 billion.

This abdication of federal responsibility is worse than it appears. Consider that heating and cooling costs amount to just 40 percent of the low income individual or family's total energy costs.

Mr. Chairman, my State -- the Commonwealth of Pennsylvania -- has seen federal funding for LIHEAP shrink from $134 million in fiscal 1986 to $104 million this year. Governor Robert Casey reports that if the President's fiscal 1989 budget proposal were enacted, federal funding would shrink by an additional $23 million. Some 70,000 households could lose their benefits entirely.

So far, the State has been able to hold the line -- 418,000 households continue to receive benefits, which average $234. But further federal funding cuts cannot be absorbed. The reason: Pennsylvania will not be allowed under the *Stripper Well* court order to appropriate additional state oil overcharge funds for LIHEAP.

In his budget proposal for State fiscal year 1988-89, Governor Casey already requested $30.7 million in state oil overcharge funds for the program. This is the maximum amount allowed under the *Stripper Well* court order, which put a cap of 75 percent on the amount of funds that can be used each year by a state on *all* low income programs. Thus, if federal spending is reduced again in fiscal 1989, the Governor will not be able to compensate by requesting a state emergency supplemental appropriation for LIHEAP, as he did this year.

Which brings me, Mr. Chairman, to my last point. Oil overcharge monies cannot be viewed as a panacea to the low income energy assistance problem. Original Congressional intent for the monies was that they be used to supplement, not supplant, a federal commitment to LIHEAP. So much for intent.

But let us ignore that intent for a moment. Surely, Congress has done so. Simply stated, oil overcharge monies are no longer adequate even to supplant federal funding for LIHEAP. States have tapped and just about depleted oil overcharge funds. Eighty percent of those funds have been allocated. What funds remain in Stripper Well accounts must by law be used for a variety of purposes, not just LIHEAP.

The National Consumer Law Center recently surveyed State LIHEAP officials to determine the impact of last year's 16 percent reduction. According to the survey, fourteen states have exhausted their oil overcharge accounts. Thirty-four states plan to reduce benefits and/or the number of households served, close their programs early, or reduce or eliminate LIHEAP transfers to low income weatherization programs.

Congress justified cutting appropriations for LIHEAP all the while ignoring that, even at its peak, LIHEAP benefits reached just one third of the families eligible. And now the oil overcharge monies are nearly spent. We have cut to the bone; now we are cutting through the bone.

Mr. Chairman, allow me to quote from the NASCSP report I mentioned a moment ago. According to the report, "(LIHEAP) assistance is a meaningful supplement to low income household budgets, but these payments, on average, are not high enough to bring the household 'energy burden', or percent of income spent for residential energy, down to its level at the time of the 1978 price explosion." Put another way, too many Americans still are relegated with the choice between heating and eating. It is a choice no American should be forced to make.

Thank you, Mr. Chairman.

Senator CHILES. I thank you, Senator. I know that the program is crucial to many, many areas of our Nation and certainly one which you have had a long interest in in your particular State.

We do find ourselves this year with an allocation that has come out of the Appropriations Committee which is considerably less than the budget allocation that we tried to get and considerably less than the House is going to have in their allocation; actually less than the President proposed for our particular subcommittee, about $100 million.

So obviously we are going to be pressed everywhere.

I note that on the basis of the President's request your State would be cut $23.5 million if the President's request became the law.

I also note that your State has available from the available stripper funds of Exxon and the remaining Exxon funds $70.8 million. I would think because this program is so important that certainly before they use those excess oil funds for other items, which we find that States do, such as fixing potholes and everything else, they would make sure that they took care of that pressing need that you have told us about of your low income people.

So there is that $70.8 million on hand to make up what at most would be a $23.5 million interest, and I certainly hope we can do considerably more for this program than the President——

Senator HEINZ. Mr. Chairman, on that point, I would like to point out that your statistics on what my State either does or would receive under the President's fiscal year 1988 budget is approximately correct.

My numbers are that our funds shrunk from $134 million to $104 million and under the fiscal year 1989 budget request to $81 million, as you say, about a $24 or $25 million cut. That, of course, means that about 70,000 could lose their benefits.

Let me also point out that for fiscal year 1989, Pennsylvania will have totally exhausted its so-called oil overcharge moneys. There will be none left from the Exxon stripper fund.

Senator CHILES. How were they exhausted? What are they going to use them for in 1989?

Senator HEINZ. It has already been appropriated for this year.

Senator CHILES. For what did they appropriate them?

Senator HEINZ. Low income energy assistance.

Senator CHILES. All of the funds went to low income energy assistance?

Senator HEINZ. I cannot swear that all of it went for low income energy assistance, but I am told that Pennsylvania not only will not have that money, but there are some 13 other States that have similarly exhausted their oil overcharge accounts.

What that means, of course, is that oil overcharge money simply cannot be viewed any longer as the panacea to low income energy assistance funding problems.

Senator CHILES. You know, I think the subcommittee would be delighted to see what your State appropriated those funds for if they have already appropriated them. We are using a General Accounting Office report that shows the availability of these funds. The report is less than 1 month old. Your legislature may have been in session since that time and may have appropriated the funds.

The subcommittee would be interested in seeing what they used the funds for, if they used them all for low income energy assistance, because we are concerned that an awful lot of States, while we hear how pressing this program is, it is a little distressing to see States—and I do not say your State because I do not know that they have done this, but numerous States have used these funds for many things that had nothing to do with low income energy assistance.

Senator HEINZ. Mr. Chairman, I cannot answer for every State, but there is a survey that was conducted by the National Consumer Law Center which was just completed of State Low Income Energy Assistance Program officials to determine the impact, notwithstanding the oil overcharge fund moneys, of last year's 16 percent funding reduction.

According to the survey, 80 percent of the oil overcharge moneys have been allocated. Thirty-four States plan to reduce benefits and/or households served, close their progams early or reduce or eliminate Low Income Energy Assistance Program transfers to the Low Income Weatherization Program.

Senator CHILES. We would like a copy of that——

Senator HEINZ. So I suggest that we have not only cut to the bone, we have cut through the bone.

Senator CHILES. Well, we would like to have a copy of that survey, too, because, again, our 1-month-old General Accounting Office report shows that $534 million is available to the States, and that is only for the 13 States that they sampled. As they say, the President's reduction would be $157 million but here is $534 million available. So somebody's study is not exactly hitting on all fours.

Senator HEINZ. Even if it were true that there was enough oil overcharge fund moneys to maintain programs at current levels next year, Mr. Chairman, I would have to point out that there have been a number of studies done, one by the national association that I mentioned earlier, that have concluded that the level of payment now made nationally is far from being even close to adequate.

Senator CHILES. I do not doubt that at all, but there is some responsibility on the part of States to try to assist. If the States are not using money that was available for oil overcharge, then they are certainly signifying that they do not give a very high priority to this.

The problem of this subcommittee is going to be taking the smaller amount of funds that we have, and the Senator from Florida tried to get more funds. We had more funds in the budget resolution. The Appropriations Committee did not see fit to divide those funds up the way the Senator from Florida would like to have seen.

Now we are going to be making choices of whether we are reducing AIDS research, Pell grants, a lot of things that the Senator from Pennsylvania is interested in just like the Senator from Florida.

Of course, when we find a pot of money out there like the oil overcharge money, we certainly think that that money should be used first, as I think the Senator from Pennsylvania does, for those people that need the low income energy assistance. When we see that many States are not doing that, that concerns us.

Senator HEINZ. Mr. Chairman, I am not quarreling with you on that point, but I think the key point that I want to make is simply this, and I will summarize very quickly.

By every measure, the existing level of payments have been reduced both in real and nominal and terms since 1985. They are now at a level lower than existed in the previous program in 1980. By any measure, they are grossly and hopelessly inadequate as of today while the oil overcharge funds are being used.

The difference between the information the committee has and that which I have is that there are still oil overcharge fund moneys available to help tide this already inadequate program through another inadequate year.

The second point, therefore, that I wish to make is if we think it is already inadequate and the facts turn out to be that there is no oil overcharge fund moneys available, what has become inadequate will become a program leading to disaster for millions of families. I know the chairman does not want that.

May I put in the record, Mr. Chairman, a resolution from the National Governors Association in favor of the Low Income Energy Policy Assistance Program; a letter from my own Governor in Pennsylvania, Gov. Bob Casey, indicating the situation in our State, which is severe; and last, a portion of a letter of which the entirety will be delivered later in the day to you, Mr. Chairman, from 50 of our Senate colleagues, including myself, urging you to do the very best you can by this program. I am pleased that one-half the Senate has agreed to sign this letter, and we will have it signed, sealed, and delivered to you before the record is closed today.

Senator CHILES. We thank you for your appearance and your strong case that you make for this.

Senator HEINZ. Mr. Chairman, I thank you for your interest and your courtesy, as always.

STATEMENT OF HON. DAVE DURENBERGER, U.S. SENATOR FROM MINNESOTA

Senator CHILES. Senator Durenberger.

Senator **Durenberger**. Good morning, Mr. Chairman, Senator Harkin. It is a pleasure to be here. I did not come to speak on low income energy assistance until I heard my colleague from Pennsylvania. Then I changed I mind. I was about to change my mind back again, but I thought before I do that I would ask you what you have on Minnesota in your GAO report? [Laughter.]

John and I spent a lot of time back in 1959 making sure that the windfall profit stacks over a long period of time was going to take care of some of this transition, and I agree with him in his plea. I would like to be on the record in saying that——

Senator **Chiles**. The Senator will be so on the record, and I wish we all could have monitored a little bit better or made sure that those windfall profits did go into low energy assistance. I am afraid many States use those like a revenue sharing and spend them for a lot of other things.

Senator **Durenberger**. I would just say for the record or for my own record, I suppose, one of the mistakes I made that year was deciding that we should not have a trust fund for windfall profits because I was against trust funds at that time. I think it turned out that was not a smart idea.

Senator **Chiles**. I think that is a mistake that several of us made, and the Senator from Florida includes himself.

Senator **Durenberger**. Mr. Chairman, thank you. I am here today to testify on behalf of a program that in dollars I guess is so small that I have to ask myself why in $1 billion budget we are spending time with it. But when I look at the two of you, I know why we are, because you can appreciate the concerns we have in our States all over this country for the future of rural hospitals.

I just want to make a few points in support of my rural health transition grant program which we were all kind enough to authorize last year and which is now in your hands to do something about and just to remind everyone that hospitals have changed a lot in America.

They used to look like this, Mr. Chairman, if they were in big cities, and they used to look like that if they were in little towns. You know, they were sort of one level, but they were all sort of rectangular places, and inside them they carried on various little pieces of business. There was a little emergency room, and there was a little surgery suite, and then there was a little place where you could go see your baby, and then a few beds.

A hospital is a hospital; just some look bigger than others. Today, as we all know, as we look across our States things have changed substantially. Some of the reasons for the change we are aware of are, one, the rapid advance of high technology. You just cannot put this million dollar diagnostic equipment in every hospital in this country.

The second thing that has happened, and we have a hand in this, is change in utilization. Hospitals are not necessarily the best place for people to go. A lot of people get sick and die in hospitals, catch infectious diseases, and so forth.

So we have changed the way we use hospitals. They become very expensive. If we can do surgeries on the outside, we do them on the outside. We do them in offices that a doctor maintains or a clinic.

We are seeing in this transition only the most severe cases actually end up in our hospitals.

We are seeing as the three of us go through nursing homes very sick people who in another era might have been in a hospital but today they are in a nursing home, particularly in small communities.

We are seeing more people with less financial ability to be in a hospital. We particularly see that in all of our rural communities. I have been in rural hospitals in both of your States, in Florida and in Iowa, and it is no different in your States than it is in my State.

At $250, $300, $350 a day, whatever it is, there are so many of our rural citizens who cannot afford to pay the bills that are required to take care of them. So what happens? The hospital pays the bill or the community pays the bill in some sense. The smaller the community and the more people of lesser income that have to use that community hospital, the harder it gets to keep that hospital going.

So we face, in America today, the possibility that these hospitals just close up and we all go to these regional centers to get our health care.

I have come to the conclusion, over a period of years, that that is not fair. That is not the American way. That is not access. That is not quality health care. What I have found in my State is that what we need in our small communities is an opportunity to change this definition. You may not change it from a rectangular shape, but you are going to change what goes on inside that facility.

For $50,000 a year for 2 years, we could provide more than 300 small community hospitals in this country the opportunity to invest in planning a strategy for change of their facility, combining some of these outpatient surgeries into their facility perhaps; combining, in some cases, some of the things that happen in a snip with the things that happen in a hospital; doing some of the outreach that big city hospitals can do as to mental health and chemical dependency and these sort of things; keeping health care and most of your medical services as close to people as possible, acknowledging that some of the tertiary care will have to be done in Des Moines or in a larger community somewhere else in your States.

But the folks just do not have the $50,000. One of the interesting things since I have floated this bill is the fact that in a community in the larger sense, maybe a region of your State in which there are six, seven, or eight small hospitals all struggling the same way, they would like to come together and apply for one of these grants and sort of jointly plan what they are going to do in which areas; should they together buy an emergency ambulance service or go into a visiting nurse or home health service or something like that.

So even though the $15 million across America does not sound like a lot of money, and I feel somewhat apologetic coming here, taking your time for that amount of money, I think I am talking to people on this committee who are receptive to the notion that with a very small investment we can help the people who are our rural communities get up with the times, if you will, in terms of providing the kind of care that is so easily accessible in the big cities of this country.

PREPARED STATEMENT

So I encourage you to look favorably on this request and to include this in your decision for this year. Mr. Chairman, thank you.

[The statement follows:]

STATEMENT OF SENATOR DAVE DURENBERGER

Mr. Chairman, thank you for giving me the opportunity to testify on behalf of the Rural Health Transition Grant Program. Recognizing the crisis facing rural hospitals, Congress authorized the Grants Program in the Omnibus Budget Reconciliation Act of 1987. I wanted to come before the Committee personally to urge inclusion of the $15 million appropriation needed for FY 1989 for this essential program.

As you know, small rural hospitals throughout the nation are experiencing severe financial difficulties. Increasingly, we hear of rural hospitals that have failed or which will soon be forced to close their doors. In 1986, one-third of rural hospitals operated at a deficit compared to only 19 percent of urban hospitals. The U.S. General Accounting Office reports that between 1966 and 1986, 446 rural hospitals closed. Sixty-three have closed in the last two years alone according to the American Hospital Association (AHA).

The crisis facing rural hospitals has a variety of causes, including the severe economic problems now facing many rural areas. Recent surveys, for example, have found that rural residents are more than twice as likely to be without health insurance as urban residents. This means that rural hospitals' budgets are being pressured to absorb a growing amount of uncompensated care.

A second factor hurting rural hospitals is the general decline we are seeing in the use of traditional hospital services. Nationwide, rural hospital occupancy dropped from 68 percent in 1976 to 55 percent in 1986. Among rural hospitals with less than 100 beds, over three-quarters were less than half full in 1985. In Minnesota, as is typical of States with a large rural population, the average occupancy rate in rural hospitals with less than 50 beds has plummeted to 34 percent and the average length of stay has narrowed to 5 days, according to AHA reports. This means that on any day there may be as few as

17 beds filled. Hospitals can't pay their fixed costs at those vacancy levels. Both changes in clinical practice and changes in public and private systems of reimbursing for inpatient hospital services have contributed to the declining use of inpatient hospitalization.

Finally, rural hospitals, which depend on the elderly for a very large portion of their business, have been hurt by biases and inequities in the Medicare payment system which compensate urban hospitals at a much higher rate--sometimes 30 to 40 percent higher per DRG. In addition, some small rural hospitals face further demands, including deteriorating physical plants and difficulty recruiting and retaining staff. All these factors are proving disastrous to rural hospitals' viability.

With the demise of these hospitals, which are the focal points for health care delivery in many rural communities, Medicare beneficiaries and other rural residents lose access to the health services they need. Once a rural community's hospital closes, doctors and other health care providers tend to flee, leaving rural residents without even basic care. And if people cannot get adequate and accessible health care--particularly for prevention and early diagnostic services--a minor problem easily may become a major, and costly, illness. To a farmer or other rural resident who suffers a heart attack or serious injury, getting to a hospital quickly can mean the difference between life and death. And, to a rural senior recovering from hip surgery or a stroke, it's critical to have convenient access to a local health care facility during what can often be a lengthy period of recovery.

Members of rural communities across the country are wondering: Will our hospital close? Will our doctors leave town? Should we try to keep the hospital's doors open? How can we be sure we'll have access to quality health care?

Many hospitals have concluded that the only alternative to financial collapse is to adapt by revamping the services they offer to meet the changing needs of the communities they serve. Hospitals could convert underused hospital beds to other uses--uses like mental health services, respite care, or chemical dependency treatment programs. Or, some smaller hospitals could convert to free-standing emergency centers, out-patient surgery centers, or home health care centers. In some areas, hospitals may be able to better coordinate services--ranging from joint purchases and shared services, to improved access to capital, to staff recruitment and joint record keeping. These revamped facilities could integrate services with other hospitals to create regional feeder systems for inpatient care, thereby improving occupancy rates and financial well being of hospitals receiving inpatients. Adaptations such as these will revitalize financially-stressed rural hospitals and ensure continuation of a health care presence in the rural areas of our nation.

Many rural hospitals are anxious to diversify and adapt to new circumstances. But, considering and making these changes take time, expertise, and money. Rural Health Transition Grants would provide resources to small (100 beds or less) rural hospitals to enable hospitals and their communities to decide upon and implement strategies for change. Grants of up to $50,000 per year could be awarded to a hospital for up to two years from the Federal Hospital Insurance Trust Fund. The grants could be used to hire outside consultants or to free up existing staff to analyze the potential demand in the hospital's trade area for new services, assess competition, and review operational, legal, and financing issues involved in adding new services. The funds could also be used to hire architects or financial and marketing consultants needed to plan and implement new services. And, finally, the grant funds could be used to finance renovation costs, although no more than one-third of any grant could be spent on capital related costs; and no funds could be used to retire debt incurred for previous construction projects.

These "Rural Health Care Transition Grants" are vital to the health of rural America. If the necessary appropriations are made, 300 small hospitals throughout rural America would benefit from the program over the next two years. The Medicare program would benefit from timely, effective, and efficient services provided to beneficiaries in appropriate settings. Perhaps most important, millions of rural Americans will be ensured access to the health care they desperately need.

I urge the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies of the Committee on Appropriations to act favorably and provide the necessary appropriation for this critically important grant program.

Thank you, Mr. Chairman, for your time and attention.

Senator **Chiles**. I thank you, Senator. I know this was authorized last year in the omnibus reconciliation bill. The President, of course, has requested no funds for it.

As I pointed out to Senator Heinz, we find ourselves in the position where we have less money given to this subcommittee than the President requested in his budget and considerably less than the budget resolution provided for. So we have to try to make do with what we have with certain programs.

Senator **Harkin** [presiding]. I also want to thank the Senator. As you almost said, you are preaching to the choir, and the only response in the choir is amen.

Senator **Durenberger**. Very good.

Senator **Harkin**. This is right on target. I see all over Iowa these small hospitals and what they are faced with. You are right. They want to change. They want to utilize the facilities, some for daycare centers, some for respite care. We did get to the swing bed authorization a few years ago, and they have been able to utilize some of their wings as swing beds for longer term care.

But they do not know how to do it. They do not know what laws are affected or what types of modifications have to be made. For just a small amount of money they can hire the people they need to tell them what to do—in many cases they get volunteers to help them do it, the community pitches in, but they do not have that kind of expertise. You are right.

Sometimes the small amounts of money, Dave, are the ones that make the biggest amount of impact out in those communities like that.

Senator **Durenberger**. I will say amen to that.

Senator **Harkin**. I appreciate your bringing this to my attention.

Senator **Durenberger**. Thank you.

Senator **Harkin**. Thank you very much. I appreciate it.

NONDEPARTMENTAL WITNESSES

Senator **Harkin**. We will call as our next witness Michael Urquhart. If I have mispronounced that I apologize, and you can correct me. He is president of the American Federation of Government Employees Local 12.

Is Mr. Urquhart here?

[No response.]

Senator **Harkin**. Is anyone here from AFGE?

[No response.]

Senator **Harkin**. OK, we are going to move on.

STATEMENT OF MARIE WINSLOW, NATIONAL FEDERATION OF FEDERAL EMPLOYEES

Senator **Harkin**. The next witness is James Peirce, president of the National Federation of Federal Employees.

[Pause.]

Senator **Harkin**. Welcome. Please identify yourself.

Ms. **Winslow**. Senator, my name is Marie Winslow from the National Federation of Federal Employees. Our president, Jim Peirce, was unable to be here. I understand my statement will be submitted in the record in its entirety, so I will summarize briefly.

NFFE represents 150,000 Federal workers across the country, a significant number of whom work for the Social Security Administration or the Indian Health Service. We would like to focus on the appropriations for these two agencies today.

Recently, SSA Commissioner Dorcas Hardy proposed a new nationwide teleservice program for SSA. The plan would involve replacing the current 1,300 SSA district offices with 20 teleservice centers located across the country. Operators at these centers would process SSA and SSI and income claims by telephone only. We would handle all the inquiries and problems that result after claims have been granted by telephone only.

In time, it would be virtually impossible for SSA claimants and beneficiaries to handle any question or problem face to face with an SSA employee.

Commissioner Hardy intends to begin the implementation of the program on October 1. The imminence of the program is so assured that when our union asked for an extra 60 days in order to bargain over the implementation, we were told there was not 60 days left.

We feel that Congress deserves the opportunity to take a careful look at Commissioner Hardy's plans before they are implemented, and in order to give Congress that opportunity we urge the subcommittee to ensure that funds are not appropriated to SSA for its nationwide teleservicing center proposal during fiscal year 1989.

The program would be come a self-perpetuating, self-fulfilling prophecy once it was begun. As toll-free numbers were installed, service at the field offices would be cut back, meaning that people would find the lines too long and would eventually call. That is how the whole program would work.

We would like to stress that the ability to file claims or address benefit questions by telephone is an important option and one that should be maintained. We feel that our current field office use of teleservicing is a good example of how far the system can go in promoting efficiency; but it also shows the limits. We believe that allowing SSA to proceed with its teleservicing plans would cause major problems.

The second issue we would like to address is funding for IHS hospitals. They are located for the most part on remote Indian reservations where they serve a population that has long been ignored and forgotten.

American Indians suffer from astoundingly high suicide rates, record unemployment, and rampant alcoholism. For many, the staff at the Indian hospital is the first place they turn for help when a crisis hits. Yet, the hospitals are grievously understaffed because of funding cuts.

PREPARED STATEMENT

We would like to request that the subcommitte ensure that appropriations for the Indian Health Service will be adequate to meet the staffing needs of the IHS hospitals.

This concludes my statement. I will be happy to answer any questions.

[The statement follows:]

STATEMENT OF MARIE WINSLOW

I appreciate the opportunity to appear today and present the views of the National Federation of Federal Employees, which represents 150,000 Federal workers across the country, a significant number of whom work for the Social Security Administration or the Indian Health Service. I would like to focus on Fiscal Year 1989 appropriations for these two agencies.

Recently, Social Security Administration Commissioner Dorcas Hardy proposed a new nationwide teleservice program for SSA. The plan would involve replacing the current 1,300 SSA district offices with only 20 teleservice centers to be located across the country. The plan also has the potential to further centralize and move the work of those remaining 20 District Offices to one mammoth telephone center which would process SSA claims and benefits for the entire country. Such a plant would most likely be constructed in Baltimore, MD.

Operators at these telecenters would process social security and supplemental security income claims by telephone only. They would handle all the inquiries and problems that result after claims have been granted or denied by telephone only. Individuals who wished to call their own district SSA offices would be rerouted electronically to the teleservice center's toll-free "800" number. In time it would be virtually imposible for most SSA claimants and beneficiaries to handle any question or problem face-to-face with an SSA employee.

Commissioner Hardy intends to begin the implementation of the nationwide teleservicing program on October 1, 1988. SSA plans to bargain over the impact and implementation of this plan with NFFE sometime this summer. The imminence of the program is so assured that a request for an extra 60 days to prepare the union's response, when made by NFFE's Social Security Council, was summarily denied. There were not 60 extra days left in the agency's implementation schedule, according to SSA management. Our testimony will highlight many problems with the nationwide teleservicing program. We feel these problems have the potential for a devastating effect on claimants, beneficiaries, and the SSA system as a whole. We further feel that Congress deserves the opportunity to take a careful look at Commissioner Hardy's plans before they are implemented. In order to give Congress that opportunity, we urge this Subcommittee to ensure that funds are not appropriated to SSA for its nationwide teleservicing center proposalduring Fiscal Year 1989.

The SSA Commissioner's centralization plan would become a self-perpetuating, self-fulfilling prophesy one it was begun. Introduction of a toll-free number would be accompanied by a reduction in staff at the district offices. As claimants had to wait longer and longer to speak to an SSA employee in person, they would become discouraged and attempt to handle their questions and problems by telephone. With an increase in telephone calls, the local office staff would be further reduced, touching off even slower service at those offices that remained open. Eventually, individuals who wished to file their claims or be assisted with a post entitlement problem in person would have to journey to one of the 20 Central Offices left in the country. This kind of journey would be an expensive proposition for most individuals. For the typical SSA claimant, it would be an impossibility.

The theory behind the Commissioner's plan is that centralization will provide more efficient service, and that once claimants have the opportunity to use a toll-free telephone number, they will no longer want to file for claims or handle benefit problems in person. We disagree most strongly with Commissioner Hardy.

We would like to stress that the ability to file claims or address benefit questions by telephone is an important option, and one that should be maintained. The Social Security offices where our NFFE members work already use teleservicing, and are a good example of how far the system can go in promoting efficiency. The experiences of those employees also show the limitations of teleservicing. We believe that allowing SSA to proceed with its teleservicing plans will cause major problems for beneficiaries and problems for the agency.

In any discussion of efficiency in filing claims for social security or SSI, it is important to understand the types of original documents necessary to process claims. Claimants must provide original birth certificates, marriage licenses, divorce decrees and military discharge papers in order to qualify for payments. Constructing a nationwide teleservice center will not alter this requirement. Beneficiaries may, of course, choose to mail these original documents to SSA. This option is available at present. And yet, the majority prefer not to let these important documents out of their possession. They would rather come into the SSA office, have official copies made while they wait, and then take their documents back home with them. In many cases now, an individual will actually go through all the steps necessary to file a claim with SSA over the telephone, but still come in with the necessary documents.

It is also important to understand the limitations of the average social security or SSI beneficiary. They are typically the elderly, the mentally or physically challenged, and survivors. NFFE's SSA employees have found that it is most effective to deal with these individuals face-to-face. Many of the beneficiaries develop a special rapport with a particular employee. They will come into the office and wait until they can see the one individual whom they trust. This carefully crafted relationship enables SSA employees to deal with the most difficult and painful problems claimants encounter. These employees have built up the necessary good will, for example, to succeed in explaining why a beneficiary must return an overpayment to the agency, and have the claimant understand and comply. Virtually every employee eventually acquires one or two special claimants with whom only they are able to cope. When they are not available, many beneficiaries simply refuse to discuss their case until their "special" employee has returned. Maintaining the option of developing this type of rapport with an SSA employee would naturally be eliminated through the creation of a nationwide teleservice center.

Another important aspect of a face-to-face discussion of a claim is the ability of the employee to determine whether the beneficiary has understood such complicated issues as reporting responsibilities. In other cases, an SSA employee is able to help a hearing-impaired individual file a claim by writing out all the information, and having the claimant write down any questions. Such attention to the comprehension of detail by a claimant would also be impossible through a telephone call.

Members of the Subcommittee may be unaware that the processing of telephone claims requires more paperwork than a face-to-face claim. Employees must send out a notice telling claimaints that they have 60 days to return certain documents and then a second notice that they have 30 days to return other forms. When a claim is filed in an SSA office, these notices are unnecessary because the work is done while the claimant is present. With the severe reduction in clerical workers already plaguing SSA offices, a massive increase in the number of teleservice claims will likely swamp the system.

A further problem with teleservice claims arises when claimants file for questionable disability benefits. A claimant with a broken leg might ask for benefits and the SSA employee is required to fill out the paperwork although he or she realizes the claim is likely to be denied. Most claimants ask if their requests are likely to be granted. When the claimant is in an SSA office and learns that his or her claim will probably be denied, it is a simple matter for the individual to sign the appropriate line. A telephone claim is different, however. Forms must be sent to the claimant, and he or she must return them to SSA. Not surprisingly, many claimants feel no need to return the signed forms, since they have realized that they will not be receiving benefits. The SSA employee, however, must send letters to the individual requesting that the appropriate forms be signed and returned so that the file can be closed. If all SSA claims must be handled through telephone calls, the backlog in SSI cases particularly will be enormous.

SSA employees are also able to build up a network of contacts in their areas that enables them to deal swiftly with eligibility questions for claimants. A question of whether assistance from local church groups need be counted as income for a beneficiary, for example, is handled much more easily by SSA employees familiar with the areas in which the claimants live.

Not the least of the benefits for maintaining an extensive network of SSA offices is the opportunity it offers for the Federal Government to have a "face" for the taxpayers. There are only three agencies that every American deals with: the Internal Revenue Service, the Postal Service and the Social Security Administration. The IRS, which has its own problems with toll-free numbers, is not fondly regarded by most Americans. The Postal Service has seen a decline in its popularity over the past two decades. The SSA is the last face-to-face contact many taxpayers have left with their Government. This is an important asset, and not one to be thrown away lightly.

The allure of a centralized telephone system has disadvantages which might not be immediately obvious. When the Veterans Administration moved to a central office system, there was such an outcry from veterans groups that many counties now staff veterans assistance centers. In addition, VA makes use of its extensive hospital system where claims may be filed. The SSA has no similar facilities, and it must be recognized that SSA not only deals with all the individuals who are aided by the VA, it must assist all the non-veterans as well.

NFFE would suggest that before any steps are taken to implement a nationwide teleservice program, that some attempt be made to survey the public and learn what type of service they would prefer. NFFE SSA employees are unaware that any efforts have ever been made to establish the public's preference for service options. We would like to reiterate that we are not opposed to teleservicing per se. On the contrary it works well in the installations represented by NFFE. But it only works well because the option of a face-to-face interview has been maintained. We feel that it is essential to maintain this option for SSA claimants and that any survey of public preferences would bolster our position. Americans pay into the Social Security system all their lives and when they need the benefits of that system they deserve to speak to an employee face to face if they want to. We strongly urge the Subcommittee to ensure that no funds are appropriated for SSA's proposed nationwide teleservice center in Fiscal Year 1989, and that Congress be given an opportunity to look carefully at the plan to eliminate almost 1,300 Social Security offices.

The second topic we would like to discuss today is that of funding for Indian Health Service hospitals. IHS hospitals are located, for the most part, on remote Indian reservations, where they serve a population that has been ignored for far too long. These forgotten Americans suffer from astoundingly high suicide rates, record unemployment and rampant alcoholism. For many, the staff at the Indian hospital is the first place they turn for help when a crisis hits. Yet the hospitals are grievously understaffed because of funding cuts. A nationwide nursing shortage has contributed to the difficulty of attracting qualified personnel to work at these remote locations. We would like to request that the Subcommittee ensure that appropriations for the Indian Health Service will be adequate to meet the staffing needs at the IHS hospitals.

That concludes my statement. I will be happy to answer any questions.

Senator **Harkin**. Thank you very much for your testimony.

I understand that Ms. Hardy testified that there would be no closing of any offices this year. They were going to see how this toll-free number worked.

I guess at first blush I thought maybe this might be a good service. I can see it perhaps as an additional service that might——

Ms. **Winslow**. Teleservicing, Senator.

Senator **Harkin**. One of the things that I can see happening now that you bring it to my attention is someone getting on this toll-free line and being put on this circular wait for 10 minutes. If he or she finally gets through and doesn't get questions answered properly, to whom will he or she then turn? To me, to Senator Harkin's office.

Lord knows, we have enough now coming in from Social Security people who do not feel that their claims are properly handled. So this might really put a heavy burden on the Senate and congressional offices to do something which we are not equipped to do.

Ms. **Winslow**. Senator, one of the things in the statement which I did not mention was we have to remember who the claimants and beneficiaries are. For the most part, they are the mentally and physically challenged and the elderly. They often develop a special rapport with one SSA employee. They will not talk to anybody else. They trust those people.

In the strategic plan 2000 which we attained, not without some difficulty, there is a reference to in the year 2000 that district offices would handle complex, face-to-face contacts. Well, I think they only plan on having 20 district offices in the entire country. Most SSA claimants do not have a lot of money. They simply cannot afford to go to 1 of the 20 offices if they are not lucky enough to live in that city.

Nearly all face-to-face service is going to be by appointment. As the plan points out, the vast majority, especially of SSI people, are mentally and physically challenged. They cannot be making an appointment.

Senator **Harkin**. I understand. I am just offering you a suggestion that you might want to think about talking to Members of the House and the Senate about how equipped they might be to handle the new workload that will be coming down the pike if, in fact, that happens.

Ms. **Winslow**. That is a good point, Senator.

Senator **Harkin**. But I still think the 800 number might be a good supplement to add to the system, but not to supplant it.

Ms. **Winslow**. We would agree with that definitely as an option. We think it can work well for people who are equipped to handle it.

Senator **Harkin**. I see some real problems with that.

Thank you very much for your testimony.

Ms. **Winslow**. Thank you, Senator.

STATEMENT OF DENNIS K. RHOADES, DIRECTOR, NATIONAL ECONOMIC COMMISSION, THE AMERICAN LEGION

Senator **Harkin**. Next is Dennis K. Rhoades, director of the National Economic Commission of the American Legion.

Welcome, Mr. Rhoades.

Mr. **Rhoades**. Senator Harkin, it is a pleasure to be here this morning. Since our remarks have been submitted for the record, I do want to focus on two points, both of which concern recently passed legislation.

Senate bill 999, which is now on the President's desk, reforms the operation of the veterans employment and training system in the Department of Labor and is largely an administrative bill. It does, however, have certain budget implications.

These are, first, S. 999 would increase the staffing of the local veterans employment representative program in the job service offices. The administration requested this year 1,252 such representatives. The new statutory formula provided in S. 999 provides for 1,600. The fiscal year 1989 difference in actual dollars we estimate would be about $14.5 million.

The second budget implication for fiscal year 1989 is the creation of the National Veterans Training Institute. We estimate that the budget for that will be about $4.5 million.

We urge your favorable consideration of the Labor Department's budget to accommodate these new provisions of S. 999.

The second point I want to talk about also concerns S. 999 but concerns the supplemental appropriation which we understand is being developed in the House which would provide an extra $50 million for the operation of the job service in fiscal year 1988.

I want to tell you that the American Legion strongly supports this measure, as the job service serves as the keystone of the Federal Government's veterans employment and training system.

Despite an increased employer tax over the last 8 years recently sustained by Congress to fund the employment service and the unemployment insurance function, the number of staff in the job service and dollar reductions have continued year by year. The result is a decline in service. One out of three Vietnam veterans visiting the employment service were placed in 1981. That has declined to one out of five. So we are definitely seeing a falling off in services.

PREPARED STATEMENT

S. 999 applies not only to fiscal year 1989 but it also applies to fiscal year 1988. We would recommend, should this supplement come over to this subcommittee for consideration, that $5 million be added to cover the provisions of S. 999.

Mr. Chairman, that concludes my statement, and I am free for questions.

[The statement follows:]

STATEMENT OF DENNIS K. RHOADES

Mr. Chairman, The American Legion is grateful to once again have the opportunity to share our views with the subcommittee regarding appropriations for veterans employment and training programs operated by the Department of Labor.

Although unemployment among veterans has declined along with the number of unemployed persons in general, there are still disturbing indications of joblessness problems among significant segments of our veteran population. For example, although veterans constitute 13-14% of the veterans' labor force, they represent 26% of all dislocated workers, according to the Bureau of Labor Statistics (BLS). Unemployment among Vietnam-era veterans ages 30-44 is running a full percentage higher than that of their non-veteran peers. Minority veterans' unemployment continues to be resistant to the general improvement in joblessness nationwide. Finally, there continues to be evidence that disabled veterans are not only experiencing high rates of unemployment as a group, but that many such veterans are not even counted as unemployed, having dropped out of the labor force out of discouragement in their search for work.

As you are probably aware, there has been considerable activity this past year regarding the authorizing legislation for those veterans programs, codified under chapters 41, 42 and 43 of Title 38, U.S. Code. The result of this activity has been the passage several weeks ago of S. 999, which amends these statutes to substantially improve the delivery of employment and training services to our Nation's veterans. The timing of this hearing is therefore fortuitous, since certain provisions of S. 999 have funding implications for the Department of Labor.

Having said that, we also hasten to add that, in our estimation, the impact of the new law on the Federal budget is minimal. In fact, it was the intent of Congress, as well as veterans service organizations such as The American Legion who consulted with the Veterans Affairs Committees on the bill, to seek improvements in the system which minimized costs, and which would better the effective use of existing resources.

This intention is nowhere better illustrated than in the codification of the National Veterans Training Institute (NVTI). Created in 1986, the Institute is operated by the Colorado Job Service and the University of Colorado at Denver, through contract with the Department of Labor. Its purpose is to upgrade the skills of Local Veterans Employment Representatives (LVERs) and Disabled Veterans Outreach Program (DVOP) staff who work for the public employment service. Many of us who have been concerned with veterans employment and training issues have long recognized that the cadre of veterans staff in local Job Service offices lacked the necessary knowledge to perform their jobs effectively. That is why we believe that the NVTI is without question the most effective veterans employment and training initiative to be implemented in the past six or seven years. It focuses not upon new personnel resources, but upon improving the effectiveness of existing staff, at a cost of approximately $3.2 million per year. We urge the subcommittee's favorable consideration of funding NVTI in fiscal year 1989.

Mr. Chairman, H.J. Res. 395, approved by Congress late last year to address the Federal deficit, had the effect of mandating an across the board reduction of 4.26% in all of the Department of Labor's programs during FY '88. These programs are thus currently operating at a level of $139.5 million. The American Legion has often testified that we would not oppose budget restraints on veterans programs provided that they were fairly applied to all programs across the board. In the case of the Labor Department programs in FY '88, the 4.26% reduction does indeed appear to have been applied uniformly. The consequence of this reduction on veterans' programs, however, has taken an unusual twist. The Solicitor of Labor ruled recently that the Department-wide reduction could not apply tc the Disabled Veterans Outreach Program (DVOP), since the number of positions to be funded by the Department were determined by formula in statute (38 USC 2003A). Since the veterans program function was still subject to the 4.26% cut, however, funding for the Local Veterans Employment representative program was required to absorb both its initial 4.26% reduction, as well as a reduction in funding which would have otherwise been applied to DVOP. This has meant a reduction in the number of LVER positions from 1379 in 1987 to 1252 in 1988 and 1989.

We mention this in the context of S. 999, because one of the provisions of the new law establishes a mandatory staffing level of approximately 1600 LVERs in the Employment Service nationwide. To put this new requirement into perspective, it should be remembered that as recently as 1981, there were nearly 2500 such Federally funded positions. The American Legion does not maintain that as many positions are needed today, but we do think that the new level of 1600 is probably the minimum which should be sustained to assure the availability of quality labor exchange services for veterans. We therefore request that the Committee support funding for the new statutory number of positions, at a level of $68.3 million for FY '89.

With regard to the budget for the Office of the Assistant Secretary for Veterans Employment (OASVET), one relatively minor item needs adjustment, in our estimation, and that is the agency's travel budget. The majority of the positions in the OASVET are located in the field, where staff provides oversight and technical assistance to the various state and local service deliverers responsible for providing employment and training assistance to veterans. The OASVET field staff is utterly dependent upon its travel--without adequate funds, well over 200 field personnel are confined to their desks and unable to perform their jobs. The agency's total travel budget in 1987 was $694,000. In 1988, owing to H.J. Res. 395, and across the board reductions in travel, that budget is only $450,000. In FY 1989, the Administration has requested a modest increase of $25,000, by no means adequate to the OASVET's mission. This is particularly true in light of several new responsibilities assigned to the field by S. 999--monitoring of service delivery area services to veterans under the Job Training Partnership Act, and of the veterans preference practices of Federal agencies in the field. In addition, OASVET will be required to provide a greater degree of technical assistance to the public employment service because of the extensive changes in the law governing services to veterans rendered by these agencies. We therefore urge that the subcommittee consider adding an additional $250,000 to the travel budget for the OASVET.

Finally, Mr. Chairman, The American Legion would like to address the issue of overall funding for the State Employment Security Agency System.

While S. 999 has made significant changes to improve the stability and accountability of veterans' assistance in the Employment Service, the impact of these changes will depend upon the health of the whole system. Over the past eight years ES has experienced wrenching changes, with the number of Federally funded personnel falling from 30,000 to approximately 17,000. Critical ancillary services, such as counseling have all but vanished in many states. In 1980, one out of every three Vietnam veterans were placed by ES; today, that ratio is one out of every five.

Mr. Chairman, we believe it is important to remember that the Employment Service is the keystone of Federally mandated employment and training services for our Nation's veterans. To diminish the capacity of the system as a whole to carry out its labor exchange functions, is to curtail, in effect, a vital part of our veterans services system.

The resource levels in effect in FY 1988, and those proposed for FY 1989 leave little doubt that service will continue to decline. Despite the subcommittee's support for $755 million funding for ES in FY '88 (the same level as FY '87), H.J. Res. 395 reduced ES funding to $723 million. For FY '89, the Administration requested another $44.5 million reduction. If this request were accepted, that would mean reduction in absolute dollars of over 10% during the two fiscal years subsequent to FY '87. We believe that the Employment Service at a minimum, should be funded at the FY 1988 appropriated level, with an increase for inflation.

In that regard, we are only asking for an increase in the allocation of monies from the Federal Unemployment Tax Act (FUTA) trust fund. The Department of Labor estimates that the fund will have an excess of $890 million in FY 1988, and $1.18 billion in FY 1989.

Mr. Chairman, we thank you again for the opportunity to appear here today. The support of this subcommittee for employment programs for our nation's veterans over the years has been gratifying, and we look forward to a continuing good working relationship with you.

Senator **Harkin**. I just want to make sure I understand. What you are asking for is $68 million in the Local Veterans Representatives Program?

Mr. **Rhoades**. Right. That is about $14.5 million more than is currently requested by the administration.

Senator **Harkin**. Exactly. Then the Employment Service is $755 million?

Mr. **Rhoades**. Yes, sir.

Senator **Harkin**. That is about $80 million more.

Mr. **Rhoades**. Yes, sir.

Senator Harkin, that $755 million was the fiscal year 1987 funding level for the Employment Service.

Senator **Harkin**. Thank you very much.

Mr. **Rhoades**. Thank you.

STATEMENT OF SYD BEANE, EXECUTIVE DIRECTOR, LINCOLN INDIAN CENTER, INDIAN AND NATIVE AMERICAN EMPLOYMENT AND TRAINING CENTER

Senator **Harkin**. Next is Syd Beane, executive director of the Lincoln Indian Center, Indian and Native American Employment and Training Coalition.

Mr. **Beane**. Senator, thank you for the opportunity to be here with you today. As you indicated, I am representing the Indian and Native American Employment and Training Coalition. I want to comment on the fiscal year 1989 budget request for the Employment and Training Administration, U.S. Department of Labor. We have submitted testimony for the record.

I am the executive director of an Indian center organization in Lincoln, NE. We are a nonprofit organization serving Indians and other disadvantaged people throughout Nebraska in Lincoln, Omaha, and western Nebraska.

Helping Indian people get and maintain productive jobs is one of the most important goals of all Indian tribes and organizations. Indian programs under title IV of JTPA and under the Indian set-aside in the JTPA Summer Youth Program make this possible.

I have attached a brief fact sheet to my statement regarding the specific details of this program. As you can see, nearly 34,000 Indian, native American, and native Hawaiian people participated in title IV activities in program year 1986. An additional 12,000 Indian Native Alaska and native Hawaiian youth were involved in the summer youth projects.

Our programs operate in the most economically depressed parts of the United States. The Bureau of Indian Affairs has estimated that the average unemployment rate in Indian country is 50 percent.

In some of our reservation areas, as high as 80 percent of our people cannot find jobs. The severe unemployment conditions on most reservations lead Indian workers to seek jobs in urban areas where they are frequently unable to compete successfully with others with higher educational levels and stronger work experience history.

Despite these conditions, one-half of our people who have gone through this program enter unsubsidized employment. Another 30 percent complete a significant educational or other employment-related goal.

However, our program is not entirely about numbers. It is really about people. I have attached a number of stories regarding individuals who have gone through our program.

One example is a lady who was 37 years of age with no education, a history of drug and alcohol abuse and facing the loss of her children. This lady sought assistance from our program. After several counseling sessions with the JTPA staff, realistic goals were set. First, this lady faced the drug and alcohol abuse problems. She successfully attained a GED, regained custody of her children, and completed courses in geriatric care. With this help, this lady was able to overcome her own problems.

The story does not end there. The lady went on to become a GED tutor in an adult basic education program sponsored by the Nebraska Department of Social Services. She has served as an Indian tutor for the Nebraska Department of Employment Services and plans to attend the community college in western Nebraska in the fall of 1988. Here we have seen an outstanding Indian person return to her community and return the help we have been able to provide her.

Although we are very proud of successes like these, we are constantly told to do more with less. Our funds were cut again in fiscal year 1988 appropriations. Since JTPA started, the funds in the Indian set-asides have dropped 36 percent in real dollars. Since 1981, the program has been slashed by 71 percent in real dollars.

We ask that you restore our title IV program to the level of $68.9 million, the amount we had the year before our JTPA started. This would be approximately a $9 million increase over the current identified amount.

Another matter, Senator, even though our matter has been sharply reduced over the last several years, the administrative burdens placed on our program by the Department of Labor have increased. We are monitored not just by one office in the Labor Department but by two completely separate offices. These offices spend much of their time examining our financial practices even though their staffs are not accountants.

We are already monitored by certified public accountants under a completely separate process.

DOL has four separate grant officers that control aspects of our funding, and we find that they do. It makes it very difficult for us to operate, and it is very expensive. We find this to be a duplication of funding through the program administration account of the Labor Employment and Training Administration.

Senator **HARKIN**. Mr. Beane, I am sorry to have to cut you off, but I am going to have to ask you to summarize. You have 30 seconds.

PREPARED STATEMENT

Mr. **BEANE**. Basically, we are asking two things. One is to increase the amount identified of approximately $9 million and look seriously at the amount of dollars going into administrative funding for the Department of Labor in terms of putting that money into direct services for native Americans.

[The statement follows:]

STATEMENT OF SYD BEANE

Thank you, Mr. Chairman, for inviting me to appear before the Committee. My name is Syd Beane. I am the Executive Director of Indian Center, Inc. in Lincoln, Nebraska, a nonprofit organization serving Indian and Native American and other economically disadvantaged people in the Lincoln area. Through our Job Training Partnership Act program, we extend our services to the Omaha area and to the western portion of the state.

I have the privilege to testify on behalf of the Indian and Native American Employment and Training Coalition, an informal network of organizations participating in the Indian programs authorized by the Job Training Partnership Act.

Helping Indian people get and keep productive jobs is one of the most important goals of all Indian tribes and organizations. The Indian programs under Title IV of JTPA and under the Indian set-aside in the JTPA Summer Youth program make this possible.

I have attached to my statement a brief fact sheet on our programs. As you can see, nearly 34,000 Indian, Native Alaskan and Native Hawaiian people participated in Title IV activities in Program Year 1986. An additional 12,000 Indian, Native Alaskan and Native Hawaiian youth were involved in Summer Youth projects.

Our programs operate in the most economically depressed parts of the United States. The Bureau of Indian Affairs estimates that the average unemployment rate in Indian Country is 50%. In some of our reservation areas as many as 80% of our people cannot find jobs. The severe unemployment conditions on most reservations leads many Indian workers to seek jobs in urban areas where they are frequently unable to compete successfully with others with higher educational levels and stronger work experience histories.

Despite these conditions, half of the people that go through our JTPA programs enter unsubsidized employment. Another 30%

complete a significant educational or other employment related goal.

However, our programs are not really about numbers, Mr. Chairman. They are about people. I would like to share with you several stories from our own program that illustrate this point.

William, a young Sioux Indian man moved to Lincoln from South Dakota. He has a wife and two children, and his wife is expecting a third child. William had experience as a law enforcement officer, but became involved in alcoholism. He and his wife felt that if they could move to a different setting and make a career change, then perhaps life would be better for their family.

The family moved to Lincoln and stayed with relatives until William was able to find housing. The Lincoln JTPA program enrolled him in an over-the-road truck driving training course sponsored by Crete Carriers and conducted by the Southeast Nebraska Community College. According to projections, this line of work is expected to pay from $50,000 to $60,000 per year in five or six years.

William passed both of his entrance tests, went to school and worked part time. He is now well on his way to a new life with great economic potential.

We can find entry level positions, such as maintenance and laborer jobs for Indian men, but believe that our people deserve more than this. We have designated education and training as a top program priority for the Lincoln Indian Center.

Our JTPA program has developed many linkages with city and state agencies and private sector businesses. Recently the City of Lincoln began a large bridge construction project. The Herbst Construction Co. received a subcontract for a portion of the work. Our JTPA program placed a Native American foreman with the company. He hired three other participants from our program on the construction crew. In a discussion with the

President of Herbst Construction, he pointed out that positive work experience is essential to the career success of Indian people. This project will provide that for our program participants.

We have a different type of success story from Western Nebraska. Flora has proven that people who need help will return the help which they receive by helping others in need.

As a 37 year old mother with no education, a history of drug and alcohol abuse and facing the loss of her children, Flora sought assistance from our program. After several counseling sessions with the JTPA staff, realistic goals were set. First, Flora faced the drug and alcohol abuse problems. She successfully attained a GED, regained custody of her children and completed courses in geriatric care. With this help, Flora was able to overcome her own problems.

But, the story does not end there. Flora went on to become a GED tutor in an Adult Basic Education program sponsored by the Nebraska Department of Social Services, has served as an Indian tutor for the Nebraska Department of Employment Services and has plans to attend Nebraska Western College in the fall of 1988. Here we have seen an outstanding Indian person return to her community the help we were able to give to her.

Although we are very proud of successes like these, we are constantly told to do more with less. Our funds were cut again in the Fiscal Year 1988 appropriations. Since JTPA started, the funds in the Indian set-asides have dropped 36% in real dollars. Since 1981, our program has been slashed 71% in real dollars.

We ask that you restore our Title IV program to the level of $68.9 million -- the amount we had the year before JTPA started.

On another matter, Mr. Chairman. Even though our money has been sharply reduced over the last several years, the administrative burdens placed on us by the Labor Department have been increasing.

We are monitored not just by one office in the Labor Department, but by two completely separate offices. These offices spend much of their time examining our financial practices even though their staffs are not accountants. We are already audited by Certified Public Accountants under a completely separate process.

DOL has four separate Grant Officers that control some aspect of our funding.

We would point out that all this duplication is funded through the Program Administration account of Labor's Employment and Training Administration. Is all this duplication necessary, Mr. Chairman? Can't something be done to get the money directed at serving our people, instead of establishing new offices at the Labor Department?

I am very pleased to have been able to appear before your Committee. I would be happy to answer any questions you may have about our programs or my testimony.

FACTS on INDIAN and NATIVE AMERICAN JTPA PROGRAMS

Authorization:

Title IV and the Summer Youth program provisions of the Job Training Partnership Act (JTPA).

Grantee Network:

Nearly 190 tribal governments, inter-tribal consortia, native Alaskan regional corporations, urban and rural off-reservation Indian organizations and one native Hawaiian group.

Program Activities:

Wide range of employment and training services, selected at grantee's option, including: skill training, remedial education, job counseling, job placement and work experience.

Program Participants:

Unemployed and economically disadvantaged Indian and Native American workers. Secondary school age, economically disadvantaged Indian youth participate in the Summer program.

The Title IV program serves almost 34,000 Indian and Native American workers per year in all parts of the U. S. The Summer Youth program serves an estimated 12,000 youth in reservation areas, Alaska and Hawaii.

Program Impact:

The program helps thousands of unemployed Indian workers upgrade their skills and find jobs. It is also a principal source of support for many reservation and urban Indian economic development projects. Thousands of reservation youth obtain their first jobs the through Summer Youth program.

During the 1986 funding cycle (the last one for which DOL has released data):

- * Nearly half of those leaving the program found employment.
- * Over 80% of those leaving the program found jobs, went on to other training or otherwise successfully completed their program activities.

These results were achieved despite the fact that Indian and Native American workers suffer the most severe labor force problems of any racial group.

- * Unemployment averages 50% on Indian reservations across the country. In some Indian communities it is measured at 60%, 70% and even 80% of the available work force.
- * Nearly 65% of those in the program had lengthy periods of unemployment or were too discouraged to even look for work before they entered the program.
- * Nearly 40% of those in the program were either very young or very old -- two of the hardest to serve age categories in employment and training programs.
- * Over 25% of those in the program were high school dropouts before they received program services.

Program Administration:

Program administered by various offices, including the Division of Indian and Native American Programs (DINAP), within the Employment and Training Administration, U. S. Department of Labor.

Funding Level:

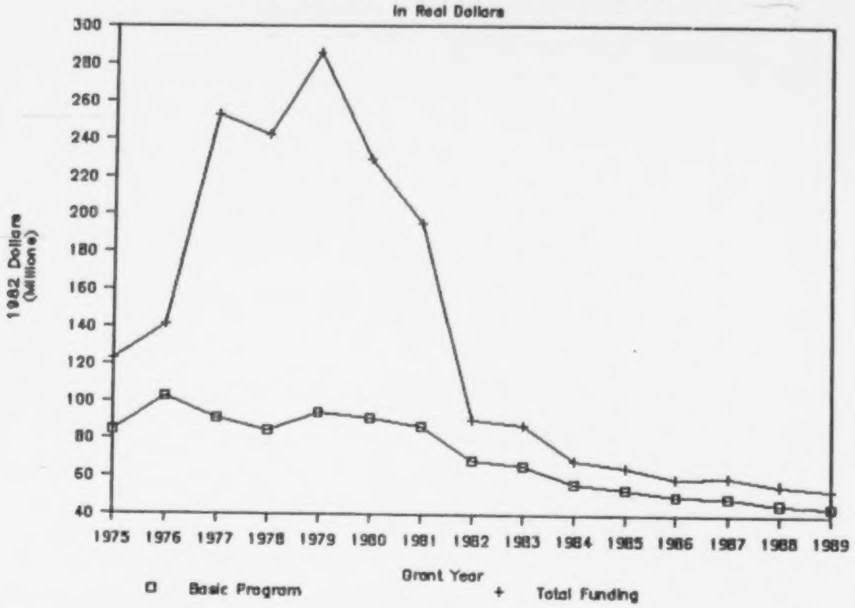
For the next funding cycle, Program Year 1988, Indian Title IV programs are funded at $59.7 million. Summer youth programs conducted next summer are due to receive an additional $13.1 million.

Reductions since 1981:

In Fiscal Year 1981, the money in all the Indian set-asides in the CETA law totaled $182.6 million. Currently the Indian set-asides in JTPA total $72.8 million. This represents a loss in support for the training of unemployed Indian and Native American workers, in real dollar terms, of 71% over the last seven years.

INDIAN JOB TRAINING FUNDING

In Real Dollars



Senator **Harkin**. As I understand it, that would be the level at which it was before JTPA started?

Mr. **Beane**. Correct.

Senator **Harkin**. Thank you very much, Mr. Beane. We appreciate your testimony.

Mr. **Beane**. Thank you.

STATEMENT OF VINCENT DORAN, PITTSBURGH JOB CORPS CENTER, ON BEHALF OF THE HOME BUILDERS INSTITUTE

Senator **Harkin**. Next is Vincent Doran, Pittsburgh Job Corps Center, representing the Home Builders Institute.

Mr. **Doran**. Thank you, Senator Harkin. The corps members and staff of the Dennison Job Corps Center send their best to you and to the entire committee.

I am pleased to appear before you today to present this statement on behalf of the Job Corps community of business labor and national labor volunteer organizations. A complete list of these organizations is included with my written statement, as well as a detailed account of our program goals for fiscal year 1989.

I am currently the center director of the Pittsburgh Job Corps Center. I have been associated with Job Corps now for 15 years and have seen thousands of corps members recruited and trained in the Job Corps.

Mr. Chairman, the Job Corps' community sincerely appreciates this opportunity to appear before you today and submit facts concerning funding needs for the Job Corps' program in fiscal year 1989. The support of this committee has been a major factor in the continued growth of Job Corps, and the results of this support are reflected in the 105 centers operating today.

Although the administration's budget recognizes Job Corps as a significant program helping our disadvantaged youth, it does not fully address the realities of running this nationwide program.

As Job Corps nears its 25th anniversary celebration, there are a few facts which help paint a clear picture of the impact this program has in helping disadvantaged youth. As you may know, a 1982 federally funded study found Job Corps $1.46 to the Government for every $1 invested in the program.

In addition, the Job Corps placement rate in 1986 was 79.4 percent. This rate is achieved with enrollees who, on the average, are economically disadvantaged 18 year old high school dropouts reading at or below a six grade level. As our slogan states, Job Corps works and so does its graduates.

For the consideration of the committee, the Job Corps community has established seven goals for fiscal year 1989. We are asking your help in making these goals a reality.

First, Job Corps must continue its services to corps members at existing centers with, at a minimum, 40,544 training slots. The unemployment rate and the high school dropout rate is of epidemic proportions in our Nation, and to cut our program now would make little sense.

Second, the Job Corps community requests the restoration of the original Job Corps capital budget. There exists a tremendous need within the Job Corps program for rehabilitation and repair activities on existing centers.

If I may interject a personal note, at the Pittsburgh center we were in a temporary facility for 16 years, a facilty that was literally falling apart. We are the only center to move in the recent past.

Our third goal is to reinstate the congressional mandate to open new Job Corps centers in areas of need.

Fourth and of major importance is to establish childcare services in Job Corps centers. This is extremely critical to increase the female participation nationwide.

Fifth, we would like to fully implement Job Corps II pilot and demonstration projects without decreasing slots at existing centers. That ties to our sixth goal.

We would further like to expand that program. It has had a cost savings of $4 million per year.

PREPARED STATEMENT

Last, we would like to initiate a longitudinal study to provide an updated examination of Job Corps costs and benefits.

My time is up. If you have any questions, Senator, I will be happy to answer them.

[The statement follows:]

STATEMENT OF VINCENT DORAN

I AM PLEASED TO APPEAR BEFORE YOU TODAY TO PRESENT THIS STATEMENT ON BEHALF OF THE JOB CORPS COMMUNITY OF BUSINESS, LABOR AND NATIONAL LABOR VOLUNTEER ORGANIZATIONS. A COMPLETE LIST OF THESE ORGANIZATIONS IS INCLUDED WITH MY STATEMENT, AS WELL AS A DETAILED ACCOUNT OF OUR PROGRAM GOALS FOR FISCAL YEAR 1989.

I AM VINCE DORAN. I AM CURRENTLY THE CENTER DIRECTOR FOR THE PITTSBURGH JOB CORPS CENTER. AS AN ADMINISTRATOR IN THE JOB CORPS PROGRAM, I HAVE HAD THE OPPORTUNITY TO WORK CLOSELY WITH JOB CORPS MEMBERS AND APPRECIATE ITS INSPIRING SUCCESS WITH DISADVANTAGED YOUTH. I HAVE BEEN ASSOCIATED WITH JOB CORPS FOR MANY YEARS AND HAVE SEEN THOUSANDS OF CORPSMEMBERS RECRUITED AND TRAINED IN JOB CORPS.

MR. CHAIRMAN, THE JOB CORPS COMMUNITY SINCERELY APPRECIATES THIS OPPORTUNITY TO APPEAR BEFORE YOU TODAY AND SUBMIT FACTS CONCERNING FUNDING NEEDS FOR THE JOB CORPS PROGRAM IN FISCAL YEAR 1989. THE SUPPORT OF THIS COMMITTEE HAS BEEN A MAJOR FACTOR IN THE CONTINUED GROWTH OF JOB CORPS AND THE RESULTS OF THIS SUPPORT ARE REFLECTED IN THE 105 CENTERS OPERATING TODAY. ALTHOUGH THE ADMINISTRATION'S BUDGET RECOGNIZES JOB CORPS AS A SIGNIFICANT PROGRAM HELPING OUR DISADVANTAGED YOUTH, IT DOES NOT FULLY ADDRESS THE REALITY OF RUNNING THIS NATIONAL PROGRAM.

AS JOB CORPS NEARS ITS 25TH ANNIVERSARY CELEBRATION, THERE ARE A FEW FACTS WHICH HELP PAINT A CLEAR PICTURE OF THE IMPACT THIS PROGRAM HAS IN HELPING DISADVANTAGED YOUTH. AS YOU MAY KNOW, A 1982 FEDERALLY-FUNDED STUDY FOUND JOB CORPS RETURNS $1.46 TO THE GOVERNMENT FOR EVERY $1.00 SPENT ON THE PROGRAM. IN ADDITION, THE JOB CORPS PLACEMENT RATE IN 1986 WAS 79.4%. THIS RATE IS ACHIEVED WITH ENROLLEES WHO, ON THE AVERAGE, ARE ECONOMICALLY DISADVANTAGED 18 YEAR OLD HIGH SCHOOL DROP-OUTS, READING AT OR BELOW A 6TH GRADE LEVEL. AS OUR SLOGAN STATES, "JOB CORPS WORKS, AND SO DO ITS GRADUATES."

FOR THE CONSIDERATION OF THE COMMITTEE, THE JOB CORPS COMMUNITY HAS ESTABLISHED 7 GOALS FOR FISCAL YEAR 1989. WE ARE ASKING FOR YOUR HELP IN MAKING THESE GOALS A REALITY.

1. JOB CORPS MUST CONTINUE SERVICES TO CORPSMEMBERS AT EXISTING CENTERS WITH, AT MINIMUM, 40,544 TRAINING SLOTS. AS YOU KNOW, THERE IS NOW AN EPIDEMIC OF YOUTH UNEMPLOYMENT AND HIGH SCHOOL DROPOUTS PLAGUING OUR NATION. IT WOULD BE EXTREMELY HARMFUL TO CLOSE ANY OF THE EXISTING JOB CORPS CENTERS. IT MAKES NO SENSE TO REDUCE A PROGRAM WHICH IS PROVING TO BE ONE OF THE BEST WAYS TO PROVIDE AMERICA'S NEEDIEST YOUTH WITH EDUCATION, TRAINING AND RESIDENTIAL LIVING.

2. THE JOB CORPS COMMUNITY REQUESTS THE RESTORATION OF THE ORIGINAL JOB CORPS CAPITAL BUDGET. THERE EXISTS A TREMENDOUS NEED WITHIN THE JOB CORPS PROGRAM FOR REHABILITATION AND REPAIR ACTIVITIES ON EXISTING CENTERS. THE ADMINISTRATION'S FISCAL YEAR 1989 BUDGET REDUCES THE EXPENDITURES FOR REHABILITATION AND REPAIR BY 26%. THIS FIGURE WILL RESULT IN AN EVEN GREATER BACKLOG OF FACILITIES IN NEED OF IMMEDIATE ATTENTION.

3. REINSTATE THE CONGRESSIONAL MANDATE TO OPEN NEW JOB CORPS CENTERS IN AREAS OF NEED. AS THE HONORABLE SILVIO CONTE STATED LAST MONTH, "THIS YEAR, THE HOUSE AND SENATE COMMITTEES LOOKED AT JOB CORPS AND DECIDED WE WANTED NEW CENTERS...THE SUBCOMMITTEES, THE FULL COMMITTEES, THE MEMBERS ON THE FLOOR OF THE HOUSE AND SENATE; EVEN THE PRESIDENT AGREED." THE MANDATE TO OPEN NEW CENTERS CAME ABOUT BECAUSE NO NEW RESIDENTIAL, FULL-SERVICE CENTERS HAVE

OPENED FOR MANY YEARS. CONGRESS RECOGNIZED THAT OPENING NEW CENTERS WOULD BE A COST EFFECTIVE, PROVEN WAY TO SERVE POVERTY YOUTH AND HIGH SCHOOL DROPOUTS. THE ADMINISTRATION'S PROPOSED FY '89 BUDGET OPPOSES THIS INITIATIVE.

4. ESTABLISH CHILD CARE SERVICES ON JOB CORPS CENTERS. THE JOB CORPS PROGRAM HAS BEEN STRIVING TO REACH ITS GOAL OF 50% ENROLLMENT FOR FEMALES SINCE ITS INCEPTION. YET, CURRENT FEMALE ENROLLMENT STANDS AT APPROXIMATELY 32%. WITH THE NUMBER OF PREGNANT TEENAGERS AND SINGLE PARENTS SKYROCKETING, LACK OF CHILD CARE SERVICES HAS BECOME A SIGNIFICANT PROBLEM FOR FEMALES IN NEED OF JOB CORPS SERVICES. WOMEN THAT WANT OR NEED JOB CORPS TRAINING ARE OFTEN SCREENED OUT OR DENIED A SLOT IN THE PROGRAM BECAUSE THEY HAVE DEPENDENT CHILDREN AND ARRANGEMENTS FOR ADEQUATE AND AFFORDABLE CHILD CARE CANNOT BE MADE. ESTABLISHING RESIDENTIAL CHILD CARE SERVICES AND FACILITIES WOULD HELP RESOLVE PROBLEMS CONCERNING JOB CORPS FEMALE ENROLLMENT, RECRUITMENT, AND HIGH CHILD CARE COSTS TO DISADVANTAGED MOTHERS.

5. FULLY IMPLEMENT JOB CORPS II PILOT AND DEMONSTRATION PROJECTS WITHOUT DECREASING SLOTS AT EXISTING CENTERS. THE ADMINISTRATION INITIATED THE JOB CORPS II PROGRAM TO DEVELOP UPDATED METHODS FOR MANAGEMENT, TEACHING, COUNSELING, AND TRAINING ON JOB CORPS CENTERS. IN ADDITION, NON-RESIDENTIAL, "SATELLITE" PROGRAMS WERE TO BE IMPLEMENTED TO HELP JOB CORPS SERVE GREATER NUMBERS OF DISADVANTAGED YOUTH EFFICIENTLY. NOW OMB IS PROPOSING TO TERMINATE THESE PROGRAMS AND/OR FORCE SLOT REDUCTIONS AT EXISTING CENTERS. THIS PROPOSAL WOULD PUT A STOP TO THE FORWARD MOVEMENT OF NEW IDEAS AND METHODS WHILE ACTUALLY CAUSING THE ENTIRE JOB CORPS PROGRAM TO TAKE A STEP

BACKWARDS. FULLY IMPLEMENTING THE JOB CORPS II INITIATIVE IS A PRACTICAL AND COST-EFFECTIVE WAY TO REACH GREATER NUMBERS OF OUR NATION'S NEEDIEST YOUTH.

6. EXPAND JOB CORPS II PILOT AND DEMONSTRATION PROJECTS TO TEST INNOVATIVE PRACTICES, ACHIEVE COST EFFICIENCIES AND EXPAND JOB CORPS SERVICES AND ACTIVITIES. IT IS ESTIMATED THAT THE $12 MILLION INVESTED IN THE JOB CORPS II PROGRAM IN 1986 WILL RESULT IN OVER $4 MILLION OF JOB CORPS CENTER COST REDUCTIONS BY 1989. JOB CORPS II WILL ALSO ALLOW FOR THE TESTING OF INNOVATIVE PROGRAMS REACHING A WIDER RANGE OF DISADVANTAGED CITIZENS. IT WOULD SEEM WASTEFUL TO CUT OFF A PROGRAM THAT HAS ALREADY PROVEN EFFECTIVE AND WILL SAVE MONEY. WOULDN'T IT MAKE BETTER SENSE TO INVEST IN JOB CORPS II NOW AND RECEIVE THE PAYBACK IN COST REDUCTIONS AND IMPROVED PROGRAMS IN YEARS TO COME?

7. INITIATE A LONGITUDINAL STUDY TO PROVIDE AN UPDATED EXAMINATION OF JOB CORPS COSTS VS. BENEFITS. GIVEN THE EVER-INCREASING PROBLEMS OF DISADVANTAGED YOUTH IN AMERICA, THE JOB CORPS COMMUNITY WOULD WELCOME AN OBJECTIVE EVALUATION OF ITS PROGRAMS. THE 1982 MATHEMATICA STUDY OF JOB CORPS CLEARLY SHOWED THE POSITIVE RESULTS OF INVESTING IN THE JOB CORPS PROGRAM. A NEW AND UPDATED STUDY WOULD PROVIDE CONGRESS WITH THE MOST RECENT AND COMPREHENSIVE DATA AVAILABLE TO MAKE POLICY DECISIONS ABOUT JOB CORPS FOR ITS THIRD DECADE OF OPERATION.

MR. CHAIRMAN, I WOULD LIKE TO MAKE SOME OBSERVATIONS ABOUT THE ADMINISTRATION'S FY '89 BUDGET REQUEST. THE ADMINISTRATION HAS REQUESTED A BUDGET WHICH WOULD ONLY MAINTAIN THE JOB CORPS PROGRAM AT ITS CURRENT OPERATING LEVEL OF 40,544 SLOTS IF CERTAIN CONDITIONS WERE MET. INFLATION FOR PROGRAM YEAR 1989 WILL HAVE TO BE HELD TO 2%. THE CONSTRUCTION BUDGET FOR JOB CORPS WILL

HAVE TO BE CUT BY 26%. NO NEW CENTERS COULD OPEN. THE JOB CORPS II INITIATIVE WOULD HAVE TO BE DISCONTINUED OR ABSORBED BY REDUCING SLOTS AT EXISTING CENTERS. THE PROBLEM OF CHILD CARE FOR DISADVANTAGED MOTHERS WOULD REMAIN. THESE OUTCOMES ASSOCIATED WITH THE ADMINISTRATION'S BUDGET WOULD CLEARLY HAMPER JOB CORPS EFFORTS TO ASSIST AMERICA'S MOST DISADVANTAGED YOUTH.

MR. CHAIRMAN, THE JOB CORPS COMMUNITY RECOGNIZES THAT YOUR COMMITTEE HAS THE UNENVIABLE JOB OF ATTEMPTING TO REDUCE OUR NATION'S DEFICIT. IT SEEMS THAT WHEN THERE IS A PROGRAM LIKE JOB CORPS, WHICH ACTUALLY RETURNS $1.46 FOR EVERY DOLLAR SPENT, YOU ARE BATTLING THE DEFICIT AND, AT THE SAME TIME, YOU ARE SAVING LIVES IN THE PROCESS! YOU SEE, THAT IS WHAT THE JOB CORPS PROGRAM ACTUALLY DOES. IT SAVES INDIVIDUALS FROM A LIFE OF DEPENDENCY UPON OTHERS AND GIVES THEM THE CHANCE TO BECOME CONTRIBUTING AND PARTICIPATING MEMBERS OF OUR SOCIETY. YOU'VE SEEN THE EVIDENCE THAT THIS IS TRUE.

THE JOB CORPS COMMUNITY FEELS THAT REALIZING THESE SEVEN GOALS IS ESSENTIAL IN STRENGTHENING A FEDERAL PROGRAM THAT HAS PROVEN ITS EFFECTIVENESS. WITH THIS COMMITTEE'S CONTINUED SUPPORT, JOB CORPS WILL ADMIRABLY SERVE OUR NATION'S NEEDIEST YOUTH. WE ARE ASKING YOU TODAY FOR THE RESOURCES TO CARRY ON. I SPEAK TO YOU AS AN ADMINISTRATOR, AS A REPRESENTATIVE OF THE JOB CORPS COMMUNITY, AND AS SOMEONE WHO HAS SEEN FIRSTHAND THE RESULTS OF A PROGRAM WHICH DESERVES OUR BEST EFFORTS.

I THANK YOU FOR YOUR TIME AND THE OPPORTUNITY TO PRESENT THIS STATEMENT.

Senator **Harkin**. As I understand it, the budget request this year is $7.10 million. You are asking for basically maintenance of services. It was $7.16 million last year. A 4-percent inflation factor would be 28, which would put you up to $7.44 million. That is really what you are asking for; correct?

Mr. **Doran**. Then the additional request for the longitudinal study, the childcare, and the pilot programs.

Senator **Harkin**. How much are you asking for?

Mr. **Doran**. $840 million, I believe, Senator.

Senator **Harkin**. $840 million?

Mr. **Doran**. There is an attachment.

Senator **Harkin**. I just did not get that far in your testimony, but if that is in here——

Mr. **Doran**. I think it is the last page.

[Pause.]

Senator **Harkin**. You might submit that for the record. I do not have it.

Mr. **Doran**. We will send it over to you, Senator.

Senator **Harkin**. Thank you very much. We appreciate it.

Mr. **Doran**. Thank you.

STATEMENT OF CYNTHIA KITLINSKI, COMMISSIONER, MINNESOTA PUBLIC SERVICE COMMISSION, ON BEHALF OF THE NATIONAL ASSOCIATION OF REGULATORY UTILITY COMMISSIONERS

Senator **Harkin**. Next is Cynthia Kitlinski, commissioner, Minnesota Public Service Commission, representing the National Association of Regulatory Utility Commissioners.

Ms. **Kitlinski**. Mr. Chairman and members of the committee, thank you very much for giving me this time this morning. My only regret is I did not coordinate with Senator Durenberger, because I am coming here to ask for funds that are competing with his particular project, and I know Senator Durenberger supports LIHEAP.

My testimony is presented on behalf of the National Association of Regulatory Utility Commissioners and NARUC's Energy Conservation Committee, of which I am a member. We are charged with protecting the public interest, and it is with this in mind that we strongly urge your support of restored funding for the Low Income Home Energy Assistance Program to the fiscal year 1987 level of $1.8 billion.

LIHEAP was initiated during the 1970 energy crisis in response to the dire need of low income households in meeting their energy bills. Even when funding for this income-based program was at its highest, it has never been adequate to serve even one-half of the eligible households now paying more than a fraction of their utility costs.

Public utilities commissioners are painfully aware of the low income family's dilemma of choosing between food and heat. The number of people living without basic utilities is growing. We believe there is a national responsibility to insure to the poor and elderly the heating and cooling needed to maintain health and a basic degree of comfort.

Since 1986, LIHEAP funding has been reduced every year. The administration's fiscal year 1986 budget request recommends an unconscionable 23-percent cut from the 1988 level. At the same time, the U.S. Department of Energy is projecting rising energy prices next year, and the eligible population is growing.

So who will take up the slack? The answer is that no one takes up the slack except the poor and the elderly themselves. These funding cuts have forced States to cut the amount of benefits and to reduce the number of households receiving assistance.

One reason often mistakenly used to cut back on LIHEAP is the existence of limited oil overcharge funds. This is not an appropriate funding source for several reasons and cannot be depended upon as an alternative to adequate Federal funding. The oil overcharge funds are intended for restitution, not substitution. The court was clear that Exxon money was to be used to supplement, not to supplant Government funds.

These funds were to have been an opportunity to increase LIHEAP grants and to address other energy programs that will help alleviate the total problem. Rather, we were forced to use the funds to mitigate LIHEAP reduction, setting back our efforts to deal with the problem through alternatives to direct subsidization.

Oil overcharge money in most cases already has been spent. Thirty-two States have allocated all of their money, and another 4 have allocated 85 percent. Therefore, it is not realistic to structure appropriations based on the assumptions that States will have oil overcharge money to make up for cuts.

While it is imperative that long-term solutions be addressed, short-term necessities prevail. Weatherization and conservation programs which contribute to the efficient use of our Nation's resources must be and are encouraged and funded. These efforts are long term, and although they help alleviate the problem, they will certainly not eliminate poverty. The desperate need of poor families, the life-threatening situation of being cut off from heat, must be addressed as well.

The NARUC, therefore, supports adequate LIHEAP funding and urges that Congress recognize the necessity of assistance for low income persons in meeting energy needs.

Further, we oppose reliance on oil overcharge funds to make up for cuts in LIHEAP allocations. The existence of overcharge moneys has consistently been used by this administration to rationalize cuts in many areas. This is neither equitable nor efficient.

PREPARED STATEMENT

At the very least, we urge you to restore funding equal to the 1987 level of approximately $1.825 billion.

Thank you very much.

[The statement follows:]

STATEMENT OF CYNTHIA KITLINSKI

This testimony is submitted on behalf of the National Association of Regulatory Utility Commissioners (NARUC). The NARUC is a quasi-governmental nonprofit organization founded in 1889 which is comprised of the governmental agencies of fifty states, the District of Columbia, Puerto Rico, and the Virgin Islands engaged in the regulation of utilities and carriers. We are charged with protecting the public interest and it is with this in mind that we urge your support of restored funding for the Low Income Home Energy Assistance Program (LIHEAP) to the FY 1987 of $1.8 billion.

The Association greatly appreciates the opportunity to address this Subcommittee to express our strong support for this extremely important program. Our support for restored LIHEAP funding is expressed in a Resolution adopted unanimously by the NARUC Executive Committee at its 1988 Winter Meeting in Washington, D.C, a copy of which is attached hereto.

LIHEAP was initiated during the 1970s energy crisis in response to the dire need of low-income households in meeting energy bills. Even when funding for this income-based program was at its highest, it has never been adequate to serve even half of the eligible households, nor pay more than a fraction of utility costs for these families. But it is still a lifeline for many families to have heat in the winter.

Whereas the average family spends 4-5% of their income on utilities, the low-income family pays 15-16% of their already meager income on utility bills. The deficits these families experience are costly in human lives and suffering. We understand the pressure that you in Congress are under with respect to a massive federal deficit, but as competing needs are weighed in the appropriations process we hope that you will realize that any reductions in LIHEAP funding are directly translated into increased hardships on those least deserving of them.

Public service commissioners are painfully aware of the low-income families' dilemma of choosing between food and heat. It is shameful that in a society such as ours the number of people living without basic utilities is growing. Just as there is a federal role in supplying food to the needy, so should there be a national responsibility to ensure this country's poor and elderly the heating and cooling needed to maintain health and a basic degree of comfort.

Since 1986, LIHEAP funding has been reduced every year. In FY 1986 it was reduced by 4.3%; in FY 1987, by 9%; in FY 1988, by 16%. The Administration's FY 1989 budget request recommends an unconscionable 23% cut from the 1988 level. Who will take up the slack? Energy prices are not being reduced simultaneously and the eligible population is growing. In fact, the U.S. Department of Energy is projecting energy prices to rise next year. The answer is that no one takes up the slack, except the poor and elderly themselves. Quite simply, these funding cuts have forced states to cut the amount of LIHEAP benefits or reduce the number of households receiving assistance.

One excuse which is consistently, but mistakenly used as a reason to cut back on LIHEAP is the existence of limited oil overcharge funds. This is not, however, an appropriate funding source for several reasons, and cannot be depended upon to act as an alternative to adequate federal funding.

First, the oil overcharge funds are intended for restitution, not substitution. The court was clear that the Exxon money was to be used to supplement, not supplant government funds. These funds were to have been an opportunity to increase LIHEAP grants, to address energy programs that will help alleviate the problem, and to look at some other methods of addressing energy needs. Rather, we were forced to use the funds to mitigate Congressionally approved LIHEAP reductions, setting back our efforts to alleviate the problem through alternatives to direct subsidization.

Secondly, oil overcharge money has in most states already been spent. Therefore, assuming that states will be able to pick up any decrease in federal funding is not realistic . Thirty-two states have allocated all of their Exxon money. Another four states have allocated 85% of those funds.

Almost one-half of the Exxon money has already been spent, and out of the $867 million in Stripper Well money received, 22 states have already allocated between 80-100% of it. Therefore, it is not realistic to structure LIHEAP appropriations based on the assumption that states will have oil overcharge money to make up any cuts.

While it is imperative that long-term solutions be addressed, short-term necessities prevail. Weatherization and conservation programs, which contribute to efficient use of our nation's resources, must be (and are) encouraged and funded. They are an investment with a guaranteed payback. But all these types of efforts are long-term and, although they may help alleviate the problem, they will certainly not eliminate poverty. The desperate need of poor families -- the life-threatening situation of being cut off from heat and water -- must be addressed as well.

The NARUC therefore supports adequate LIHEAP funding, and urges that Congress recognize the necessity of assistance for low-income persons in meeting energy needs. Further, the NARUC opposes reliance by Congress on oil overcharge funds to make up for cuts in LIHEAP allocations. The existence of oil overcharge monies has consistently been used by this Administration in a smoke and mirrors game to rationalize cuts in many areas. This is neither equitable nor efficient. At the very least, we urge you to restore funding equal to the 1987 level of approximately $1.825 billion.

Resolution Urging Congress to Restore Critical Federal Funding for the Low Income Home Energy Assistance Program for FY 1989

WHEREAS, The National Association of Regulatory Utility Commissioners (NARUC) recognizes the critical role that the Federally-funded Low Income Home Energy Assistance Program (LIHEAP) has played in providing assistance to millions of households in meeting their energy needs; and

WHEREAS, The NARUC adopted a Resolution Urging Congress to Increase the Funding for the Low Income Home Energy Assistance Program and the Weatherization Assistance Program at its 1984 Winter Meeting in Washington, D.C.; and

WHEREAS, LIHEAP is a needs-based income supplement program serving only very needy households, the majority of which have incomes of less than $5,000, or one-half what is considered to be "poverty level"; and

WHEREAS, LIHEAP funds help to pay the heating and cooling bills of approximately 6.8 million households, provides emergency energy assistance to those in urgent life-threatening situations, and may be used for weatherization of low-income households; and

WHEREAS, The average LIHEAP-eligible household spends 16 percent of its income on energy, which is four times that paid by non-low income households; and

WHEREAS, LIHEAP has never received funding sufficient to help more than 30 to 40 percent of households eligible for assistance and only covers a small percentage of the heating and cooling costs of households which do receive assistance; and

WHEREAS, The program has suffered a cut of 25 percent over the past two years (from $2.01 billion in FY 1986 to $1.5 billion in FY 1988) despite the obvious continued need for energy payment assistance; and

WHEREAS, In its FY 1989 budget request the Administration has recommended an additional funding cut of $344 million, or 23 percent, from the FY 1988 funding level; and

WHEREAS, These funding cuts have forced States to cut the amount of LIHEAP benefits and/or reduce the number of households which receive assistance; and

WHEREAS, The U.S. Department of Energy is projecting that average residential prices for all primary heating fuels will rise in 1988; and

WHEREAS, The monies States have received from the oil overcharge cases are designed to make up for past injury and are required to be used to supplement, not supplant existing Federal and State resources; and

WHEREAS, Congress has tried to force States to use these limited oil overcharge funds to replace lost Federal dollars, thereby taking away from low-income households the additional benefits they should be receiving from these cases; now, therefore, be it

RESOLVED, That the Executive Committee of the National Association of Regulatory Utility Commissioners, assembled in its Winter Committee Meeting in Washington, D.C., reaffirms its support for LIHEAP and opposes the use of oil overcharge funds to supplant, rather than supplement, necessary Federal dollars; and be it further

RESOLVED, That the NARUC urges Congress to provide sufficient funds to restore funding to a level of $1.899 billion, equal to the FY 1987 level of services.

Sponsored by the Committee on Energy Conservation
Adopted March 3, 1988

Senator HARKIN. Thank you. I was just looking at some of these figures on LIHEAP and the reductions that are coming.

Well, Ms. Kitlinski, thank you for your testimony. Basically what you are asking for is about $1.8 billion?

Ms. KITLINSKI. Yes.

Senator HARKIN. OK, thank you very much.

Ms. KITLINSKI. Thank you very much.

STATEMENT OF JOYCE McKENNA, DIRECTOR OF INFORMATION SERVICES, NATIONAL COUNCIL OF SENIOR CITIZENS

ACCOMPANIED BY ENID CASMER, SENIOR POLICY ANALYST

Senator HARKIN. Next is Lawrence Smedley, executive director of the National Council of Senior Citizens.

Ms. McKENNA. Mr. Chairman, my name is Joyce McKenna. I am the director of information services for the National Council of Senior Citizens. Mr. Smedley, who was called out of town, sends his apologies.

We have submitted a longer statement for the record. I am accompanied by Enid Casmer, our senior policy analyst.

Members of the subcommittee, Senator Harkin, we appreciate the opportunity to appear before this committee to discuss several issues of extreme importance flowing from older persons.

The first is the Low Income Energy Assistance Program, LIHEAP, which provides critical aid to poor families who need help in paying their heating or cooling bills. Nationally, 38 percent of households receiving benefits contain an elderly member, and more than one-half of those receiving summer crisis assistance are elderly. Most receive no other form of welfare assistance.

A recent report sponsored by NCSC profiled the energy use patterns of the elderly poor. These households spend 18 percent of their income on home energy costs, nearly four times as much as nonpoor households. After paying for housing, food, and utilities, they have left just $9.48 a week to pay for all other necessities such as medicine, clothing, or transportation.

To such a family, the LIHEAP program is a lifeline. Older persons are particularly susceptible to both hypothermia and heat stroke. During the great heat wave of 1980, over 15,000 persons lost their lives. Seventy percent of the victims were over the age of 65.

The average LIHEAP grant in fiscal year 1987 was just about $208 a year. If the fiscal year 1988 was distributed proportionately, the average benefit loss this year would be $33 or 7 percent of the discretionary income of the elderly poor.

While current services would raise LIHEAP funding to $1.6 billion, that would only allow maintenance of an already diminished service capacity. NCSC urges funding above current services to address the continuing serious need for energy assistance.

On another issue, the meals, services, and employment opportunities provided by the Older Americans Act are extremely important to our Nation's older citizens. At a bare minimum, NCSC urges current services funding for all titles of the OAA.

The Older Americans Act Amendments of 1987 authorize a demonstration program designed to inform the elderly poor of their possible eligibility for SSI, Medicaid, and food stamp benefits. At present, only about one-third of the elderly poor receive such assistance, though many more are eligible.

Studies of nonparticipation by the elderly point to the lack of knowledge about programs as a predominant reason. The OAA demonstration program would use the established structure of the State and area agencies on aging to disseminate information on these programs, assist potentially eligible persons in applying for benefits, and evaluate the effectiveness of the outreach efforts. We request $10 million to fund this program.

Finally, title V of the Older Americans Act provides employment opportunities for low income older persons who might otherwise depend on welfare. Last year, title V funds were cut, resulting in the loss of nearly 1,000 jobs. Now 11 States have passed legislation raising the minimum wage, and other States are considering such legislation.

In addition to the minimum wage increases, the recent reauthorization of the act created two national contractors serving native Americans and Asian Pacific islanders. To maintain all job slots to accommodate these factors, NCSC estimates that an appropriation of at least $355 million is needed.

PREPARED STATEMENT

Thank you for the opportunity to present our views. I would be happy to answer any questions.

[The statement follows:]

STATEMENT OF LAWRENCE T. SMEDLEY, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Chairman Chiles, members of the Subcommittee, I am Lawrence Smedley, Executive Director of the National Council of Senior Citizens. We appreciate the opportunity to appear before this committee to discuss appropriations for programs within your jurisdiction. We are well aware that funding pressures are particularly intense this year for domestic discretionary programs. The decisions this committee must make are probably the most difficult of any Congressional committee, as the Labor-HHS-Education Sub-committee funds human service programs which are vital to many vulnerable segments of our population.

LIHEAP

The Low-Income Home Energy Assistance Program (LIHEAP) provides critical aid to poor families who need help paying their heating or cooling bills. Nationally, 38 percent of households receiving benefits contain an elderly member and more than half of those receiving summer crisis assistance are elderly. Most receive no other form of welfare assistance.

A recent report sponsored by NCSC and the Villers Advocacy Associates ("Double Jeopardy: The Impact of Energy Taxes on Low-Income Households") profiled the energy use patterns of the elderly poor. These households spend 18 percent of their income on home energy costs--nearly four times as much as non-poor households. The average elderly poor household has an annual income of just $5,306. After paying for housing, food and utilities, they have left just $493. This means just $9.48 a week to pay for all other necessities such as medicine, clothing or transportation.

To such a family, the LIHEAP program is a lifeline. Older persons are particularly susceptible to both hypothermia and heat stroke. The inability to adequately heat or cool one's home can be life-threatening. To remain at a safe temperature, there is a limit to how far the thermostat can be turned down.

The elderly poor must spend nearly as much on home heating as the non-poor. Those who use gas or electricity spend 84 percent as much and those who heat with oil spend more than 90 percent as much as the non-poor. The elderly poor who heat with oil spend an average of $1,083 a year; gas or electricity, $871 a year.

Three successive years of cuts to the LIHEAP program have resulted in smaller benefit levels and fewer families served. From a high of $2.1 billion in FY 1985, the program has been cut by 29 percent, to its FY 1988 level of $1.5 billion. Last year's cut alone was 16 percent. The average LIHEAP grant in FY 1987 was just about $208 a year. If the FY 1988 cut was distributed proportionally, the average benefit loss this year would be $33--or seven percent of the discretionary income of the elderly poor.

While current services would raise LIHEAP funding to $1.6 billion, that would only allow maintenance of an already diminished service capacity. NCSC urges funding above current services to address the continuing serious need for energy assistance.

We dispute the notion that states do not need full LIHEAP funding because of the availability of oil overcharge funds. Funds distributed under the Exxon and "Stripper Well" cases have been largely allocated. A recent report by the National Consumer Law Center indicated that about 80 percent of these funds are no longer available. States have used nearly half of all Exxon funds for low-income programs--21 percent for LIHEAP and 26 percent for weatherization. The distribution of additional new oil overcharge monies is governed by the "Stripper Well" agreement. That settlement allows expenditure of funds for purposes such as bridge and road repair, airport maintenance and reduction of airport user fees. Low-income programs are hard-pressed to compete with these popular public works projects. Consequently, only about eight percent of

"Stripper" fund allocations have been dedicated for LIHEAP, and it is not reasonable to expect this proportion to dramatically increase.

Older Americans Act

The meals, services and employment opportunities provided by the Older Americans Act are extremely important to our nation's older citizens. Last year, several new and important provisions were funded, but, unfortunately other OAA programs were cut to pay for these new services. At a bare minimum, NCSC urges current services funding for all titles of the OAA.

SSI Outreach

The Older Americans Act (OAA) Amendments of 1987 authorized a demonstration program designed to inform the elderly poor of their possible eligibility for SSI, Medicaid and Food Stamp benefits. Last year, NCSC joined with the American Association of Retired Persons, the National Caucus and Center on the Black Aged, the National Association of State Units on Aging and the Villers Advocacy Associates in working closely with the authorizing committees to craft this proposal.

At present, only about one-third of the elderly poor receive SSI, Medicaid or Food Stamps though many more are eligible. Studies of non-participation by the elderly point to lack of knowledge about programs as the predominant reason.

The OAA demonstration program would use the established structure of the State and Area Agencies on Aging to disseminate information on these programs, assist potentially-eligible persons in applying for benefits and evaluate the effectiveness of the outreach efforts.

In order to implement this program nationally, an appropriation of $10 million is required. We believe this expenditure would result in an improved quality of life for eligible persons who do not currently receive benefits.

Title V

Title V of the Older Americans Act provides employment opportunities for low-income older persons who might otherwise depend on welfare. Last year, Title V funds were cut from $336 million to $331 million. That reduction led to the loss of nearly 1,000 jobs, from 65,738 enrollees to the current level of 64,807.

Eleven states have passed legislation raising the minimum wage, and other states are considering such legislation. Listed below are actions taken in states in which NCSC administers Title V.

	Present Wage	Increase	Effective Date
California	$3.35	$4.25	7/1/88
Connecticut	$3.75	$4.25	10/1/88
Massachusetts	$3.65	$3.75	7/1/88
Minnesota	$3.55	$3.85	1/1/88
		$3.95	1/1/90
Rhode Island	$3.65	$3.75	7/1/88

Congress is also considering an increase in the Federal minimum wage. The Title V law requires that workers be paid the highest of the Federal or state minimum wage or the prevailing wage for the job being performed.

NCSC has estimated that the following number of employees will have to be dropped in our projects: California 225 jobs; Connecticut 79 jobs; Massachusetts 58 jobs; Minnesota 17 jobs; and Rhode Island 18 jobs. Nationally, NCSC employs only about 16 percent of all Title V workers. However, when all contractors, and state recipients, absorb the impact, the losses will be substantial.

At this time, the Congressional Budget Office has not yet estimated the full funding level needed to maintain all job slots while accommodating the already enacted minimum wage increases in the aforementioned states. Added to this need for funding will be the costs of the two new national contractors created in the recent reauthorization of the Older Americans

Act. These would serve Native Americans and the Asian/Pacific Islanders.

NCSC has estimated that an appropriation of at least $355 million will be required to maintain the current, 1987-1988, authorized enrollment level plus the spaces to be provided the two new national contractors. If a Federal minimum wage increase is approved, $381 million would be necessary. In addition, with state minimum wage increases, the current maximum level of $5,111 annually per enrollee will not be sufficient.

Thank you for the opportunity to present our views. I would be happy to answer any questions.

Senator HARKIN. Thank you very much for your testimony. I appreciate it from a fine organization.

Ms. MCKENNA. Thank you.

Senator HARKIN. Thank you very much.

STATEMENT OF PAUL HANNA, FORMER SECRETARY OF FLORIDA STATE LEGISLATIVE COMMITTEE, ON BEHALF OF AMERICAN ASSOCIATION OF RETIRED PERSONS

ACCOMPANIED BY JOEL REID, FEDERAL AFFAIRS STAFF

Senator HARKIN. Next is Paul Hanna, former Secretary of Florida State Legislative Committee, representing the American Association of Retired Persons, another fine organization.

Mr. HANNA. Senator Harkin, on behalf of the more than 28 million members of the American Association of Retired Persons, thank you for this opportunity to testify concerning fiscal year 1989 funding for programs under this subcommittee's jurisdiction.

My name is Paul Hanna, and I am former chairman of the AARP State Legislative Committee of Florida. I am accompanied by Joel Reid of AARP's Federal affairs staff.

AARP's highest priority is to see a significant restoration of funds to the Low Income Energy Assistance Program. The association supports LIHEAP funding at the fiscal year 1987 level of $1.8 billion. At a minimum, however, we strongly urge that this program be funded at the current services level plus inflation.

A succession of Federal cutbacks in LIHEAP since fiscal year 1985 has reduced its funding by about $570 million, despite the fact that fewer than one-third of eligible households actually get served. Past assumptions that cuts in Federal appropriations would be restored through other funding sources available to the States have just not materialized.

LIHEAP is critical to low income older Americans who are especially vulnerable to harm from weather extremes. Although LIHEAP pays a portion of the energy bill for low income households, this assistance makes a crucial difference, especially to seniors who disproportionately reside in LIHEAP households.

One AARP member receiving LIHEAP assistance in Montana recently reported: "For the first time I am able to pay all my households bills and keep my thermostat turned up to 62 degrees all winter."

LIHEAP beneficiaries have been victimized by dubious assumptions about spending priorities at the State level, with the result that they have literally been left out in the cold. This occurred despite promises to protect critical low income programs.

Oil overcharge funds are available for a variety of uses, and only a portion of such funds are spent on LIHEAP. Generally speaking, it is not appropriate to assume that States will use these funds to completely restore Federal LIHEAP cuts.

Second, the association supports a fiscal year 1988 adjustment to $346 billion in the funding level for the title V Senior Community Service Employment Program. This is necessary to accommodate State minimum wage increases and thereby avoid layoffs of older workers by title V sponsors.

AARP supports shifting unobligated funds from other Department of Labor programs to title V as a revenue neutral adjustment. If this adjustment is not possible for fiscal year 1988, we urge that it be made for fiscal year 1989.

PREPARED STATEMENT

AARP's other recommendations are detailed in our larger statement for the record.

Thank you, Mr. Chairman.

[The statement follows:]

STATEMENT OF PAUL HANNA

ON BEHALF OF THE MORE THAN 28 MILLION MEMBERS OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP), THANK YOU FOR THIS OPPORTUNITY TO TESTIFY CONCERNING FY 1989 FUNDING FOR PROGRAMS UNDER THIS SUBCOMMITTEE'S JURISDICTION. MY NAME IS PAUL HANNA, AND I AM FORMER SECRETARY OF THE AARP FLORIDA STATE LEGISLATIVE COMMITTEE.

AARP'S RECOMMENDATIONS CAN BE SUMMARIZED AS FOLLOWS:

1) PROVIDE A SIGNIFICANT RESTORATION OF FUNDS TO THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP); ENSURE, AT A MINIMUM, CURRENT SERVICES FUNDING (CURRENT SERVICES PLUS INFLATION) FOR LIHEAP.

2) PROVIDE NO LESS THAN FY 1988 FUNDING FOR OLDER AMERICANS ACT (OAA) PROGRAMS ADMINISTERED THROUGH THE ADMINISTRATION ON AGING ($724.7 MILLION).

3) RAISE THE FY 1988 APPROPRIATION FOR THE SENIOR COMMUNITY SERVICE PROGRAM (SCSEP, TITLE V OF THE OAA) TO $346 MILLION TO ACCOMMODATE MINIMUM WAGE INCREASES (OUTLAY IMPACT IN FY 1988: $3 MILLION). ASSUMING THE ABOVE ADJUSTMENT, AARP RECOMMENDS CURRENT SERVICES FUNDING FOR SCSEP IN FY 1989.

4) INCREASE FUNDING FOR MEDICARE CONTRACTORS IN FY 1989 TO REFLECT INCREASED CLAIM VOLUME AND ADMINISTRATIVE CHANGES IN MEDICARE.

5) INCREASE FUNDING FOR MEDICARE STATE NURSING HOME CERTIFICATION PROGRAM TO ALLOW FOR NEW MANDATED RESPONSIBILITIES.

6) PROVIDE SUFFICIENT FUNDING TO MAINTAIN CURRENT SERVICES IN THE GERIATRIC HEALTH CARE TRAINING PROGRAM.

7) CONTINUE FUNDING AT CURRENT SERVICES LEVELS FOR RESEARCH BY THE NATIONAL INSTITUTES OF HEALTH.

A. LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

THE ASSOCIATION SUPPORTS RESTORATION OF LIHEAP FUNDING TO THE FY 1987 LEVEL OF $1.8 BILLION. RECOGNIZING THAT BUDGET CONSTRAINTS MAY PREVENT CONGRESS FROM RESTORING FUNDS TO THIS LEVEL, WE STRONGLY URGE THAT SOME SIGNIFICANT RESTORATION BE

MADE, GIVEN A SUCCESSION OF FEDERAL CUTBACKS IN THE PROGRAM OVER RECENT YEARS. WHILE THIS SUBCOMMITTEE ULTIMATELY HAS DISCRETION TO FUND LIHEAP AT ANY LEVEL IT WISHES, I WOULD MENTION THAT THE HOUSE AND SENATE BUDGET RESOLUTIONS BOTH ASSUME FUNDING FOR THE PROGRAM AT CURRENT LEVEL PLUS INFLATION. PAST ASSUMPTIONS THAT CUTS IN FEDERAL APPROPRIATIONS WOULD BE RESTORED THROUGH OTHER FUNDING SOURCES AVAILABLE TO THE STATES HAVE GENERALLY NOT MATERIALIZED. CUMULATIVELY ABOUT $570 MILLION HAS BEEN CUT FROM THE PROGRAM SINCE FY 1985 DESPITE THE FACT THAT FEWER THAN 1/3 OF ELIGIBLE LOW INCOME HOUSEHOLDS ACTUALLY GET SERVED.

LIHEAP IS CRITICAL TO LOW INCOME OLDER AMERICANS, WHO ARE MOST VULNERABLE TO HEAT STROKE AND HYPOTHERMIA AND ARE THEREFORE GIVEN PRIORITY FOR SERVICE. OF THE LOW INCOME HOUSEHOLDS RECEIVING WINTER HEATING AND SUMMER COOLING ASSISTANCE, 38 PERCENT AND 56 PERCENT, RESPECTIVELY, HAVE HAD AT LEAST ONE OLDER OCCUPANT. LIHEAP PAYS ONLY A PORTION OF THE ENERGY BILL FOR LOW INCOME HOUSEHOLDS (AVERAGE ANNUAL BENEFIT FOR HEATING WAS $213 IN FY 1986), BUT THIS ASSISTANCE OFTEN MAKES A CRUCIAL DIFFERENCE. AN AARP MEMBER IN MONTANA RECENTLY CALLED TO REPORT, UPON RECEIPT OF LIHEAP ASSISTANCE, "FOR THE FIRST TIME, I AM ABLE TO PAY ALL MY HOUSEHOLD BILLS, AND KEEP MY THERMOSTAT TURNED UP TO 62 DEGREES ALL WINTER." (EMPHASIS ADDED)

DESPITE FEDERAL PROMISES TO PROTECT CRITICAL LOW INCOME PROGRAMS, LIHEAP BENEFICIARIES HAVE BEEN REPEATEDLY VICTIMIZED BY DUBIOUS ASSUMPTIONS ABOUT SPENDING PRIORITIES AT THE STATE LEVEL. THE RESULT HAS LITERALLY LEFT THEM OUT IN THE COLD.

WHILE MANY STATES USE PORTIONS OF THEIR OIL OVERCHARGE ALLOCATION FOR LIHEAP, THE TOTAL OIL OVERCHARGE MONIES SPENT ON LIHEAP HAVE NOT BEEN SUFFICIENT TO OFFSET THE TOTAL REDUCTION FROM THE FEDERAL PROGRAM. IN FACT, WEATHERIZATION IS THE PREFERRED LOW INCOME APPLICATION. AARP DOES NOT OPPOSE THE USES OF OIL OVERCHARGE FUNDS BY THE STATES; WE SIMPLY POINT OUT THAT IT IS NOT APPROPRIATE TO ASSUME THAT STATES EITHER PLAN TO, DESIRE TO, OR WILL BE PERMITTED BY THE COURTS TO COMPLETELY RESTORE FEDERAL LIHEAP CUTS.

B. OLDER AMERICANS ACT/ADMINISTRATION ON AGING

THE ASSOCIATION RECOMMENDS THAT FUNDING FOR OLDER AMERICANS ACT PROGRAMS ADMINISTERED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES BE CONTINUED AT NO LESS THAN FISCAL YEAR 1988 LEVELS.

TODAY, MANY AGED PERSONS ARE ABLE TO LIVE INDEPENDENTLY IN THEIR OWN HOMES BECAUSE OF EFFECTIVE AND INNOVATIVE SUPPORTIVE SERVICES, MEALS, PROGRAMS, TRAINING, RESEARCH AND DEMONSTRATION PROVIDED BY THE ACT.

C. TITLE V SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

THE ASSOCIATION SUPPORTS FY 1988 ADJUSTMENT IN THE FUNDING LEVEL FOR THE TITLE V SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM (SCSEP) TO $346 MILLION. A REVENUE NEUTRAL APPROACH WOULD SHIFT UNOBLIGATED FUNDS FROM OTHER DEPARTMENT OF LABOR PROGRAMS TO TITLE V. ELEVEN STATES HAVE ALREADY ENACTED MINIMUM WAGE INCREASES, AND HIGHER WAGE RATES WILL FORCE LAY OFFS OF SOME OLDER WORKERS. THE AVERAGE PER ENROLLEE COST (CURRENTLY $5,111) WILL NOT ACCOMMODATE THE MINIMUM WAGE INCREASES. THE ASSOCIATION IS NOT OPPOSED TO STATE OR FEDERAL MINIMUM WAGE INCREASES; WE JUST WANT TO ASSURE THAT EXISTING SCSEP ENROLLEES ARE NOT TERMINATED. IF THIS CANNOT BE ACCOMPLISHED FOR FY 1988, WE WOULD URGE THAT THIS ADJUSTMENT BE MADE FOR FY 1989.

D. MEDICARE CONTRACTOR FUNDING

AARP URGES THE SUBCOMMITTEE TO PROVIDE A REALISTIC LEVEL OF FUNDING FOR MEDICARE CONTRACTORS IN FISCAL YEAR 1989. CONTRACTORS ARE RESPONSIBLE FOR REIMBURSING MEDICARE BENEFICIARIES AND PROVIDERS, AND PROVIDE TECHNICAL ASSISTANCE AND INFORMATION ABOUT CHANGES IN THE MEDICARE PROGRAM. WITHOUT REASONABLE FUNDING, WE CAN EXPECT FURTHER DELAYS AND ERRORS IN PROCESSING PAYMENTS FOR BENEFICIARIES AND PHYSICIANS.

E. NURSING HOME INSPECTIONS

AARP SUPPORTS INCREASED FUNDING FOR THE MEDICARE STATE NURSING HOME CERTIFICATION PROGRAM TO MEET NEW DEMANDS OF THE NURSING HOME QUALITY ASSURANCE PROVISIONS OF THE 1987 OMNIBUS BUDGET RECONCILIATION ACT. THE STATE CERTIFICATION PROGRAM

ENSURES THAT ALL INSTITUTIONS AND AGENCIES WHICH PROVIDE SERVICES TO MEDICARE BENEFICIARIES MEET QUALITY AND SAFETY STANDARDS.

F. GERIATRIC TRAINING

AARP SUPPORTS FUNDING SUFFICIENT TO MAINTAIN CURRENT SERVICES FOR FEDERAL PROGRAMS IN GERIATRIC HEALTH CARE TRAINING. THE RAPIDLY AGING POPULATION AND THE ESTIMATED SHORTAGE IN HEALTH CARE PROFESSIONALS UNDERSCORE THE NEED FOR FEDERAL SUPPORT OF GERIATRIC TRAINING.

G. NATIONAL INSTITUTES OF HEALTH

AARP SUPPORTS CONTINUED FUNDING AT THE CURRENT SERVICES LEVEL FOR RESEARCH CONDUCTED BY THE NATIONAL INSTITUTES OF HEALTH. THE TWELVE RESEARCH CENTERS WHICH COMPRISE NIH HAVE PLAYED IMPORTANT ROLES IN ADVANCING NOT ONLY AGING RESEARCH, BUT RESEARCH TO BENEFIT ALL GENERATIONS.

CONCLUSION

AARP APPRECIATES THE SUBCOMMITTEE'S CAREFUL CONSIDERATION OF THESE RECOMMENDATIONS AND STANDS READY TO WORK CLOSELY WITH MEMBERS AND STAFF AS YOU PROCEED TOWARD MARKUP OF A BILL FOR FY 1989.

Senator HARKIN. Thank you very much, Mr. Hanna. Thank you again for your testimony from AARP which is, again, a very outstanding organization. We appreciate it. Thank you.

STATEMENT OF DR. LANCE LAMPORT, NATIONAL COLLEGIATE ATHLETIC ASSOCIATION AND EVALUATOR, NATIONAL YOUTH SPORTS PROGRAM

ACCOMPANIED BY RUTH BERKEY, NATIONAL PROGRAM DIRECTOR, NATIONAL YOUTH SPORTS PROGRAM

Senator HARKIN. Next is Dr. Lance Lamport and Ruth Berkey representing the National Collegiate Athletic Association, concerning the National Youth Sports Program.

Dr. LAMPORT. Senator Harkin, I appreciate the opportunity to be here today. I am the program director at St. Petersburg Junior College in Florida and a National Youth Sports Program evaluator.

I am accompanied by Ms. Ruth Berkey, the national program director of the National Youth Sports Program.

We are here in support of a $7 million fiscal year appropriation for the 1989 National Youth Sports Program. Because this is the 20th year of the National Youth Sports Program and because we have served over 100,000 children in 20 years, 58,000 students last year in 117 cities in 40 States, we feel very proud of the fact that the program accomplishes many things.

One of the things is that it brings children onto a college campus and exposes them to the college facilities, college personnel, and college experience which they normally would not have an opportunity to do.

In addition to the sports activities that are one of the primary goals of the program, the National Youth Sports Program has four unique activities that are indigenous specifically to the National Youth Sports Program in general.

The first thing is that they provided last year alone over 58,000 medical examinations and followups. In those 58,000 examinations, there were 7,000 preexisting conditions that were identified that would not normally be identified for children that lived in impoverished communities.

In addition to the medical examinations that are usually given free by local hospitals, the opportunity for followup is very important because of the fact that some of these children's health-related problems relate to their success in school.

Furthermore, the program provides a hot daily meal, at most programs, sponsored by the USDA, and the approved meal is probably the only meal that a child will get during that time period. The time period that we are really talking about is from approximately June through August where different programs start at different times for 5 consecutive weeks in the summertime.

One of the most interesting parts of the National Youth Sports Program activities is called the Enrichment Program. The Enrichment Program for 20 years has stressed some very topical issues that are in today's newspapers. One is drug and alcohol abuse education information. That information has been on the foreline of the National Youth Sports Program for 20 years. We have stressed that, and we continue to do so.

In the last few years we have added activities and information concerning teenage pregnancy prevention, suicide prevention, obviously AIDS, job opportunities, staying in school, college careers, and a variety of educational and enrichment activities that enhance the learning experience.

One of the important things about this program is that the evaluators go out into the community and are able to identify the programs that are very successful.

For instance, for every $3 donated by the colleges and the community, the Federal Government has to put up only $1. My personal experience in this program has been 17 years—and I realize my time is running short but I would like to strongly encourage you to support this program.

From 1976 through 1987 we stayed at $5.8 million. Last year we received a $453,000 increase to put us at $6.3 million. We are asking for $7 million in appropriations for 1989 to restore some lost services of food, transportation, and lost programs because of the fact that the Federal money has stayed the same and yet cost has continued to increase.

PREPARED STATEMENT

Thank you very much for listening, and I or Ms. Berkey will be glad to entertain any questions.

Senator HARKIN. Thank you very much. We appreciate your testimony.

[The statement follows:]

STATEMENT OF LANCE LAMPORT

Mr. Chairman and members of the Subcommittee, my name is Lance Lamport. I am Program Director of the Physical Education Department at St. Petersburg Junior College in St. Petersburg, Florida. This year is my 17th year of involvement with the National Youth Sports Program ("NYSP"). I worked in the NYSP project at the University of New Mexico from 1972 to 1974, and thereafter started NYSP projects at Lewis-Clark State College in Idaho, Oklahoma State University, and St. Petersburg Junior College. Most recently, I served as an NYSP evaluator for five years. Joining me today is Ruth M. Berkey, the NYSP National Program Director. We appreciate this opportunity to testify in support of an appropriation of $7 million for the FY 1989 NYSP.

This year marks the 20th anniversary of the NYSP. Each summer, the NYSP brings thousands of disadvantaged boys and girls, ages 10-16, onto college campuses. There they receive a free medical examination and follow-up; free daily U.S.D.A.-approved meals; and a daily enrichment program addressing such areas as drug and alcohol abuse prevention, health and nutrition, teen pregnancy and teen suicide prevention, AIDS, and educational and job opportunities. In addition, they receive high-quality instruction in competitive and lifetime sports. In 1987, 57,780 needy boys and girls participated in NYSP projects at 135 colleges and universities (about 30 percent of which are not National Collegiate Athletic Association ("NCAA") members) in 117 cities in 40 states. Some 58,502 free medical examinations were performed and over 1.4 million free U.S.D.A.-approved meals were served.

At least 90 percent of the youngsters participating in each NYSP project must meet the HHS Poverty Income Guidelines. Special efforts are made to enroll "high risk" youth. A significant side benefit of the program is that it provides summer employment for many residents of poverty target areas.

The NYSP uses the medium of sports to attract and motivate under-privileged youngsters to reach for and to achieve high goals and to complete a college education. For most participants, the NYSP is their first exposure to a college campus and gives them otherwise unavailable access to some of the finest educational, cultural, and athletic facilities. Many NYSP instructors are past participants who provide positive role models. This constructive experience in the college environment helps to direct the energies of these "children at risk" into constructive channels and to turn them away from destructive behavior patterns.

All NYSP projects are reviewed annually in a process that includes on-site review and a written evaluation. Financial reporting is monitored with a program of sample auditing. Institutions unable to meet the NYSP's high standards are culled out and replaced by others better able to perform the work.

Since the inception of the NYSP in 1968, the NCAA has administered the program without charge. Ruth Berkey serves as NYSP National Program Director and is assisted by others on the NCAA staff. The NCAA also donates office space and supplies and pays for NYSP-related legal fees and telephone and postage expenses; travel and meeting costs of NYSP Committee members, who volunteer their services; most travel, hotel, and per diem expenses of NYSP project personnel and evaluators; and the professional fees of NYSP evaluators.

The NCAA is an association of over 1,000 four-year colleges and universities and affiliated organizations established to govern intercollegiate athletics and to serve its member institutions and college student-athletes. The disadvantaged youngsters who participate in the NYSP therefore are not part of the population the NCAA exists to serve and the program is not one for which NCAA funds -- which are those of its member institutions -- normally would be spent. The NCAA donates its assistance to the NYSP as a community service. In 1988, the NCAA will increase its contribution to the NYSP by 13 percent to $377,700.

Participating colleges and universities donate educational and sports facilities, as well as equipment and services of a project administrator. Last year, these contributions were valued at more than $10 million. Businesses and state and local governments contributed an additional $3.2 million. By combining federal, state, local, and private resources, the NYSP again last year was able to provide more than $3 in high-quality services for each federal dollar appropriated, and to operate at a federal cost of only about $100 per child.

No federal funds are allocated to the NCAA or to individual institutions for overhead. The federal funds appropriated go directly into providing services that benefit the low-income youngsters.

Among the contributed services are medical and dental examinations provided at no or reduced cost. In 1987, the monetary value of these services was estimated to be nearly $1.9 million. Over 7,000 pre-existing medical problems were identified, including the following:

Dental problems	1,829	High blood pressure	179
Sight correction	1,589	Asthma	597
Hearing problems	849	Elevated protein in urine	391
Heart conditions	655	Scoliosis	230
Obesity	653		

The medical examination has been, and continues to be, one of the most beneficial aspects of the NYSP; it provides the opportunity for disadvantaged youngsters, who in many cases have never had a physical examination before, to receive an examination and follow-up treatment for medical problems that are identified.

Each year from 1976 to 1987, the NYSP received about $6 million in federal support. While federal funding held relatively steady, operating costs increased sharply. For example, NYSP nutrition costs alone jumped over 1500 percent from 1984 to 1986. Despite NCAA efforts to identify and attract other sources of funding, by 1987, the sharply rising costs, combined with the declining value of the federal contribution, had begun to take their toll. Salary ceilings had been instituted, the number of projects sponsored and participants had dropped, the number of operating days had declined, transportation had been cut back, hot meals at some projects -- which often are the only hot meals that NYSP participants receive — had been replaced by cold box meals, and medical follow-up had been reduced.

Between 1985 and 1987, the number of projects, already down from 142, fell from 140 to 135, and the average number of operating days per project (without taking into account days lost as a result of lost projects) fell from 30 to 24.75, for a decline of 834 operating days. The cost of restoring those lost operating days, using an average cost of $1,600 per operating day, would be $1,334,400. To restore medical follow-up to its prior level, an average of $2,000 per project would be needed, for a total $276,000. To reinstate the level of transportation previously provided would cost an average of $10,000 per project, for a total of $1.38 million. These examples illustrate some of the purposes for which additional funding still is needed to restore services previously provided to disadvantaged youngsters by the NYSP.

In FY 1988, an additional $453,000 in federal funding was provided for the NYSP. We greatly appreciate this increase. We are using it to begin to restore some of the lost services. Three additional projects are planned this year, for a total of 138. Hot meals will be served at all sites. Transportation at five projects will be restored. Much still remains to be done.

Our appropriation request this year of $7 million by no means represents the amount needed fully to restore lost services. It must be recognized that, in real dollars, the $6.319 million appropriated for FY 1988 represents just over half what was provided in 1976 ($6 million x 1.9964 BLS Consumer Price Index inflator = $11.98 million). We have reduced our request this year from the $9 million we requested last year in recognition of the severe budgetary constraints facing this Subcommittee. We hope that, over time, Congress can further increase the appropriation to bring the NYSP back to its past level of service.

On this, the 20th anniversary of the NYSP, it is important to look back to the roots of the program and why it was established. The NYSP represents, in part, a response to the urban unrest in our nation's cities in the late 1960's. In a March 1, 1988 update to The Kerner Report entitled Race and Poverty in the United States Today, the 1988 Commission on the Cities states that "[p]overty is worse now than it was twenty years ago. More people are poor — both white and non-white. Those who are poor are poorer. Escape from poverty is harder." The report urges the government make a recommitment to human investment to avoid needless destruction of "our human capital."

The NYSP is a low-cost/high-yield human investment of the type urged by this report. It is a high-quality program that works. It is not the place to economize. We therefore request that you recommend an appropriation of $7 million for the NYSP in FY 1989.

Thank you very much for the opportunity to testify this morning.

STATEMENT OF JIM NOLAN, CHAIRMAN, LEGISLATIVE COMMITTEE, NATIONAL ENERGY ASSISTANCE DIRECTORS' ASSOCIATION, INC.

Senator HARKIN. Next would be Jim Nolan, chairman of the Legislative Committee of the National Energy Assistance Directors' Association, Inc.

Mr. NOLAN. Thank you, Mr. Chairman. I am Jim Nolan. I am the director of the Montana Low Income Home Energy Assistance Program and chairman of the Legislative Committee of the National Energy Assistance Directors' Association. Our association represents State agencies which operate the LIHEAP block grant. We appreciate the courtesy you have extended us in allowing us to testify today.

This year, the President's request again reflects a massive reduction in Federal aid to low-income households to help them meet their home energy needs. The $1.8 billion will reflect a 40-percent reduction in 4 years. That reduction would mean that a program which now serves less than 40 percent of those eligible is even further constrained from helping the Nation's poor.

We surveyed our association's membership to see how they implemented the 16-percent cut last year and what this additional cut would mean in fiscal year 1989. I hope you would find the survey results which are attached to my testimony interesting.

Forty-five percent of the respondents said that they had cut heating benefits in fiscal year 1988. One-third said they had reduced the number of households served. An additional 34 percent said they had eliminated or reduced the use of LIHEAP funds for weatherization.

Interestingly enough, almost one-half of the respondents said that they had, in fact, used oil overcharge moneys to supplement the LIHEAP program. We think each of the survey results illuminates part of the problem the States are grappling with as they try to meet the energy needs of the poor.

When States cut LIHEAP benefits, as 20 of the 44 respondents did, a bad situation becomes worse. As Senator Heinz said, the Northeast Midwest Congressional Coalition recently described in their report that last year only 16 percent of eligible households' home energy costs were met by Federal assistance. If the cuts the President has recommended are agreed to by Congress, that percentage will go down to 13 percent.

An interesting sidelight that we are now finding from the States' perspective is the fact that their ability to administer the program was compromised last year and will be even more compromised next year.

Administrative costs are limited to 10 percent of the block grant. If the administration's request is approved, there will be $80 million less available for administration than there was in fiscal year 1986.

Even though administrative costs are not a particularly sexy topic, it is of interest to the Congress that this would result in even less service being made available to low-income people. States have said that if their ability to administer the program is continued to be compromised, one of the first steps they would do would be to curtail their outreach attempts to find persons in need of the program.

Congress has rightfully mandated that we not limit the program strictly to people on public assistance but to the elderly and handicapped, to try to go out and find the elderly and handicapped people. The fewer the dollars are, the less outreach staff the community action agencies would hire.

Another facet of interest to us is the fact that Federal housing programs are now using nonpayment of utility bills as a reason for eviction.

PREPARED STATEMENT

Thank you, Senator Harkin. I would be glad to answer any questions you may have.

Senator HARKIN. Thank you very much, Mr. Nolan. I understand you are basically asking for $1.6 billion?

Mr. NOLAN. We would appreciate the fiscal year 1987 level of $1.8 billion.

Senator HARKIN. Thank you very much.

[The statement follows:]

STATEMENT OF JIM NOLAN

Mr. Chairman and distinguished members of the Subcommittee, I am Jim Nolan, Director of the Montana Low Income Home Energy Assistance Program (LIHEAP) and Chairman of the Legislative Committee of the National Energy Assistance Directors' Association.

Our Association represents state agencies which operate the LIHEAP block grant. Our purpose is to help ensure that federal funds for energy assistance to the nation's poor is delivered as effectively and efficiently as possible.

It is an honor to be allowed to present testimony to you on the FY 1989 LIHEAP budget. This subcommittee's concern for this program and the people it is intended to serve are well-known and very much appreciated by those of us at the state level.

This year, the President again requests a massive reduction in federal support for this needed service and we would like to present to you what this would mean.

The $1.18 billion in the Administration's request would mean that in four years, support for the program would have been reduced by 40%. Such a reduction means that a program which serves less than a third of those potentially eligible now, as is the case with LIHEAP, is constrained even further from helping the nation's poor.

We surveyed our Association's membership to determine how states responded to the FY88 cut and what options they would consider for FY89 should a cut of another third of a billion dollars be forthcoming. You will find the results of that survey attached to my testimony.

I hope the results will be of interest to you. Please keep in mind that some states answered positive to more than one measure so the results will total more than 100%.

In FY88,

- Forty-five (45%) percent of the respondents said they had cut heating benefits.
- Thirty-four (34%) percent said they had reduced the number of households served.
- Thirty-four (34%) percent said they had eliminated or reduced the use of LIHEAP funds for weatherization.
- Forth-eight (48%) percent said they had used oil overcharge funds to supplement LIHEAP.

Each of these survey results illuminate part of the overall problem states face as the grapple with decreasing federal resources and increasing demand.

When states cut LIHEAP benefits, as 20 of the 44 respondents did, a bad situation becomes worse. As the recent report issued by the Northeast-Midwest Congressional Coalition described, last year only 16% of eligible low income household energy costs were met by federal assistance; if Congress agrees to the additional cuts in FY89, only 13% of those costs will be covered next year.

When states reduce the number of households served, as 15 states did this year, a similar effect is realized. If the FY87 program only served 30% of eligible households, an FY89 program funded at $635,000,000 less would mean that an additional 12,500,000 families would not be served.

When states reduce the use of LIHEAP funds to help low-income people weatherize their homes, as 15 states did, an opportunity to conserve a precious national resource is also wasted. Weatherization, properly funded and administered, is a natural complement to LIHEAP and can lessen demand for fuel bill assistance.

Should the LIHEAP appropriation again be reduced in FY89, the states report more of the same; lowered benefits, tightened eligibility, programs closing earlier, elimination of weatherization transfers, crisis programs and summer cooling programs.

Next year, several states also report that their ability to administer LIHEAP effectively will begin to be severely affected. Administrative costs are, by LIHEAP statute, limited to 10% of each state's grant. If the Administration's FY89 appropriation request is approved, it will mean that there will be $80,000,000 less available for Administration of the program than was available in FY86. I realize administrative costs are not a particularly "sexy" topic but there is a direct impact on the people we serve. First, some states are having to curtail their outreach attempts to find persons who have needed the program. Congress has, rightfully so, mandated that we not limit participation in LIHEAP to only those on other assistance programs but has asked that we find and try to serve eligible elderly and handicapped households. As funds for outreach staff become less available, our ability to do that is threatened. Another negative effect of fewer administrative dollars is that some states are looking at less stringent income verification and eligibility reviews because they have less staff to handle their caseloads. What then happen is that LIHEAP may serve persons not eligible, thereby diverting already inadequate fuel assistance from persons who should be served.

Another new facet of decreasing federal LIHEAP affects housing efforts for the poor. We have been informed that non-payment of utility bills is now grounds for eviction from federally-subsidized housing. Persons receiving lowered LIHEAP benefits, or receiving none at all, are clearly more vulnerable to non-payment of utility bills and may find themselves evicted from their homes, adding to an already serious homeless problem.

We do appreciate the federal deficit you are facing. The fiscal situation you deal with is not one we envy, but I think that the major argument used by proponents of a lower federal LIHEAP funding level, specifically that states have oil overcharge funds, and lowered LIHEAP funding is thereby acceptable, is faulty.

Oil overcharge funds are restitutionary in nature. To receive these funds Governors have to certify that they will be used to supplement rather than supplant existing efforts. For Congress to do what the states cannot, to supplant existing federal efforts, would seem to violate the restitutionary principle of the oil overcharge settlement.

It is also important to note that even if states wanted to use all their overcharge funds for LIHEAP, DOE has ruled that impermissible. I believe DOE's rationale is that since these funds are intended to be restitutionary to a broad range to constituents including farmers, shippers and the general motoring public, targeting funds to one group alone is not approvable.

Along those same lines, it should be noted that because oil overcharge funds cannot be used for such a variety of purposes, competition for their use at the state level is intense. Low-income people and agencies like ours that advocate on their behalf face stiff competition from many different groups for those funds. I think the fact that 21 of the 44 states in our survey have been able to secure some oil overcharge funds for LIHEAP speaks well for their efforts and should not be used as a reason for decreasing funds. That other states have not used oil overcharge funds for LIHEAP underscores why a federal energy assistance program is needed. I applaud and encourage federal efforts to step in and assist people who, for whatever reason, are not receiving aid for other levels of government.

One final point on oil overcharge funds is, I believe, appropriate. Although it is difficult to predict how much will ultimately be made available to the states, it appears that, from the last major settlement, the Texaco case, there may be about $425 million which will be distributed to states over a period of 5 1/2 years. LIHEAP has been reduced more than that in the last two years. Oil overcharge funds are no longer available in any substantial amount to help low income people.

The National Energy Assistance Directors are asking for your continued efforts on their behalf and to approve funding at the level contained in the Senate's Budget resolution.

Thank you, Mr. Chairman and members of the committee for your kind attention.

STATE RESPONSE TO LIHEAP REDUCTIONS

	MEASURES TAKEN IN FY1988				OPTIONS CONSIDERED IF FY1989 FUNDING REDUCED		
State	Served Fewer Households	Lowered Benefits	Other	Used Overcharge Funds ($ M)	May Serve Fewer Households, Tighten Elig.	May Lower Benefits	Other
Alabama	X		Closed Early Cut/Limit Weatherization Transfer		X	X	Stricter Crisis Limit Outreach
Alaska		X	Cut/Limit Weatherization Transfer Eliminated Supplemental Grant				
Arizona	X	X		X ($.9)			Limit Benefits to Public Assistance Households
Arkansas	X	X		X ($3)		X	Eliminate Crisis and Summer Program - Decrease Outreach an Require Client Co-pay
California	X	X		X ($5.5)		X	Possible PVE Funds
Colorado		X				X	
Connecticut				X ($3.2)			Possibly Use PVE Funds
Delaware			Cut/Limit Weatherization Transfer	X ($.3)	X	X	No Weatherization Transfer Close Early
Florida		X	Cut/Limit Weatherization Transfer			X	

	MEASURES TAKEN IN FY1988				OPTIONS CONSIDERED IF FY1989 FUNDING REDUCED		
State	Served Fewer Households	Lowered Benefits	Other	Used Overcharge Funds ($ M)	May Serve Fewer Households, Tighten Elig.	May Lower Benefits	Other
Hawaii		X				X	Possible Loss of Contractors Because of Admin. Reduction
Idaho	X	X			X	X	Emergency Program Only Reduce Outreach No Weatherization Transfer Admin. Funding Problem
Iowa		X			X		
Kansas	X	X	Cut/Limit Weatherization Transfer	X ($4.3)	X		Eliminate Cooling Program Restrict Applications to Funds Available
Kentucky	X			X ($1)	X		Plan for President's Budget being Approved. Include Contingency Plan if Higher Level Received
Louisiana	X	X	Possible Early Close	Possible	X	X	
Maine	X		Cut/Limit Weatherization Transfer	Possible	X	X	Reduce Weatherization Transfer
Maryland				X ($4.7)		X	Reduce Weatherization Transfer

State	MEASURES TAKEN IN FY1988				OPTIONS CONSIDERED IF FY1989 FUNDING REDUCED		
	Served Fewer Households	Lowered Benefits	Other	Used Overcharge Funds ($ M)	May Serve Fewer Households, Tighten Elig.	May Lower Benefits	Other
Massachusetts			Early Close	X ($10)			
Mississippi	X		Stricter Requirements for Emergency Aid. No Transfer to Other Block Grants	(250K)			
Missouri		X	Close Early Cut/Limit Weatherization Transfer		X	X	Reduce Transfer to Social Services Block Grant Reduce Funding for Crisis Program - Close Early
Montana		X			X		Use All Oil Overcharge Resources
Nebraska		X	Cut/Limit Weatherization Transfer				
Nevada							Use Oil Overcharge Resources
New Hampshire	X		Cut/Limit Weatherization Transfer	X	X	X	Reduce Weatherization Transfer Reduce Administrative Staff/Sites
New Jersey	X			X ($10)			Use All Oil Overcharge Resources Available

	MEASURES TAKEN IN FY1988				OPTIONS CONSIDERED IF FY1989 FUNDING REDUCED		
State	Served Fewer Households	Lowered Benefits	Other	Used Overcharge Funds ($ M)	May Serve Fewer Households, Tighten Elig.	May Lower Benefits	Other
New Mexico		X				X	Reduce Application Workers
New York							
North Carolina			Cut/Limit Weatherization Transfer	X ($3)			Reduce Transfer to Other Block Grant
North Dakota			Cut/Limit Weatherization Transfer		X		Reduce Transfer to Other Block Grant - Close Early
Ohio							Reprogram Oil Overcharge Funds
Oklahoma	X	X	Cut/Limit Weatherization Transfer	X ($1)		X	Close Early
Oregon	X		Close Early Cut/Limit Weatherization Transfer	X ($1.8)	X		Less Outreach Later Start
Puerto Rico				(20M) Proposed			
Rhode Island				X ($2.1)		X	Close Early
South Carolina		X		X ($1)	X	X	Fewer Households to Receive Emergency, Weatherization Help

State	MEASURES TAKEN IN FY1988 Served Fewer Households	Lowered Benefits	Other	Used Overcharge Funds ($ M)	OPTIONS CONSIDERED IF FY1989 FUNDING REDUCED May Serve Fewer Households, Tighten Elig.	May Lower Benefits	Other
South Dakota				X ($1.28)	X	X	
Tennessee				X ($2.5)		X	
Texas		X	Cut/Limit Weatherization Transfer	Possible ($2.25)			Eliminate Summer Cooling Program
Utah		X				X	Delay Program Opening Close Early Reduce Crisis Program
Vermont			Cut/Limit Weatherization Transfer				
Virginia				X ($5.7)			Seek Oil Overcharge Funds
Washington			Close Early	X ($.4)			Alter Program Structure Self Declaration of Income Fewer Income Verification
West Virginia				Possible			
Wisconsin				X			

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	MEASURES TAKEN IN FY1988				OPTIONS CONSIDERED IF FY1989 FUNDING REDUCED		
State	Served Fewer Households	Lowered Benefits	Other	Used Overcharge Funds ($ M)	May Serve Fewer Households, Tighten Elig.	May Lower Benefits	Other
Wyoming	X	X					

JBN/080

STATEMENT OF DAVID BRADLEY, NATIONAL COMMUNITY ACTION FOUNDATION

Senator **Harkin**. Next, David Bradley, National Community Action Foundation, another outstanding organization.

David, welcome to the committee.

Mr. **Bradley**. I would like to submit my statement for the record, and I would appreciate just making a couple of small comments on the community services block grant.

The administration is again proposing this year sharp reductions in CSBG. The arguments that they have come up with this year are a little different than in years passed. They are raising the question of administrative cost, and high excessive overhead by community action agencies. It is just another argument by the administration who opposes the program.

I would point out that HHS approves all the plans that the States submit. They have never raised a question with the States, and the States are not in turn raising questions with the community action agency. So it is not cropping up anywhere except in the administration's testimony on the Hill both in front of this committee and on the House side.

I wish that we had a favorable administration. I wish we could come here and say that we support the administration's request. We do not have that luxury today, but we may have it in the future.

In terms of specific requests, I want to start off by saying I understand and appreciate fully the pressures that this committee faces this year. You have a difficult task, and I am sure that every witness that will be testifying in next few weeks is going to be talking about more money.

I want to point out a couple of things that we need. First is the demonstration partnership, a very small program connected with the community services block grant. It is for small, innovative, new ideas in delivering services to the low income. When we lost LEO and the Community Services Administration in 1981, we lost the laboratory.

I was not sure who was going to Chair today, but your State of Iowa has a plan for family self-sufficiency for which they are looking for this Federal match.

Funded at $2.9 million in 1988, its authorization level is $5 million, and I would hope that you could fund it at $5 million.

Second, the block grant and discretionary fund. We are substantially below 1981, but we are also substantially below the sharply reduced authorization levels of 1986. We could make the arguments whether they be on program services such as helping mitigate some of the fuel assistance cuts, for instance, whether it is delivering services to the homeless. In Senator Chiles' case, it is heavy involvement with the census for 1990. We could make the case State after State that community action agencies are doing the job.

I would just point out that in virtually every area but this administration, the country is relying more on community action agencies. Service is up, and support is way up.

We simply request you do the best. We are substantially below authorization level, and that gives some flexibility.

Finally, I will add one final comment, and that is on fuel assistance. You have heard a lot of good testimony today. It reflects the same concerns that we have in terms of where fuel assistance has been cut and where it should be funded.

PREPARED STATEMENT

We appreciate your support in the past, and I wish you the best of luck in the future. Thank you.

[The statement follows:]

STATEMENT OF DAVID BRADLEY

Good morning, I am David Bradley, here today on behalf of the National Community Action Foundation, which is the Washington representative of the nation's 900 Community Action Agencies. Mr. Chairman, I am grateful to be able to testify in front of this Subcommittee.

The Administration has again requested a drastic reduction in the Community Services Block Grant; the first step toward a phase out some time in the future.

As in years past, they have argued that the gap caused by reduced CSBG monies can be filled by other funds such as the Social Services Block Grant, Head Start, Low Income Energy Programs, Community Development, Job Training, and others.

Mr. Chairman, as the Subcommittee is aware, and I might add as most communities in America are aware, tremendous funding pressures exist on those programs as well.

Having been unsucssesful in previous years with this argument, the Administration is now also arguing that some community action agencies have high administrative costs and therefore CSBG funding can be cut. The GAO gave CAA administration a clean bill of health in 1986 and I am unaware of any state comptrollers having concern over this matter.

I might add that HHS approves all state plans on how CSBG monies are to be spent. They have never questioned CAA administrative cost in these plans. It is simply that those who understand how community action agencies work understand how esential CSBG funding is to the success of many anti-poverty programs.

CSBG funds are used to staff outreach centers, help pay for coordination of volunteers, as well as suplementing many other program needs. For example, CSBG pays for the distribution of food commodities. This year many CAAs used it for Energy Assistance Outreach to keep scarce fuel payment dollars.

Mr. Chairman, the average CAA director makes less than $29,000 per year. The average CAA employee makes significantly less than $6.00 per hour.

Concerning our specific FY 1989 CSBG program needs:

1) $2 million should be added above FY 1988 for the Demonstration Partnership Program. The program, first funded in FY 1987, is used for new and innovative programs that get people off of welfare and on to the payroll. In FY 1987 five grants were funded. Attached is a listing of those programs. Even the Administration is very positive about the Partnership Program. Awards for FY 1988 go out in September after the current competition ends.

2) Funding for the Block Grant and the Discretionary Fund. Mr. Chairman, I understand the difficult funding choices the committee faces for FY 1989. Many programs such as Head Start, LIHEAP, Education, and CSBG desparately need funding increases. I will only point out that CSBG is substantially below its sharply reduced authorized level of $430 million. In state after state of the members of the committee, community action agencies are a very vital component in delivering necessary services and advocacy within the state.

Mr. Chairman, leaving aside the drastic cuts of 1981, CSBG has not kept pace and has not increased since 1982. This is inspite of an increase in counties served, hundreds of thousands of additional individuals served, increased responsibilities such as drug and alcohol abuse education and homeless.

Mr. Chairman, I wish we had an administration that officially would support this program. We don't. Unofficially yes, officially no. We have to depend on you, the Congress, to help maintain the steady progress I feel our programs have made in the states over the last seven years.

Mr. Chairman, our agencies have also been deeply involved in trying to mitigate the impact of the cuts in the LIHEAP program. Your leadership and that of the distinguished ranking member, Mr. Weicker, kept the reductions from being the full scale disaster that was threatened. However, Community Action Agencies have been unable to adequately serve many eligible LIHEAP households who formerly received help. The 1988 cuts were too deep; there was serious impacts on many low income people, in spite of use of state oil overcharge funds.

We are also submitting for your record an analysis of DOE price figures showing all fuels but oil have risen over the decade, have stayed high, and are expected to rise again. Oil of course is only used by 13% of the poor. Further, we have presented typical examples of the impact of reduced funding on clients in several states. We hope you will be able to restore funding well above the current services level for this critical source of support for the clients we serve.

Thank you Mr. Chairman for your time and support.

PRICE INDICES
1981 = 100

	oil index	gas index	lpg index	elec Index	Approp. Index)	low income fuels (weighted avg index)
1981	100	100	100	100	100	100
1982	97	121	104	111	101	113
1983	90	141	125	116	104	127
1984	92	143	130	121	112	130
1985	88	143	126	126	114	130
1986	66	136	128	126	109	125
1987	67	128	125	126	99	118
1988	69	131	125	129	83	120

prices

	#2 oil $/gal	res'l gas $/mcf	LPG retail $/gal	elec. to residences $/kwh
1981	1.19	4.29	0.57	0.062
1982	1.16	5.17	0.59	0.069
1983	1.07	6.06	0.71	0.072
1984	1.09	6.12	0.74	0.075
1985	1.05	6.12	0.72	0.078
1986	0.78	5.83	0.73	0.078
1987	0.80	5.51	0.71**	0.078
1988	0.82*	5.63*	0.71**	0.080*

*DOE est
**NCAF est.

All prices from USDOE Short-Term Energy Outlook

SUMMARY OF THE FIVE FISCAL YEAR 1987 DEMONSTRATION PARTNERSHIP PROJECTS

1. ACCORD Corporation, Belmont, New York

The applicant will receive $248,708 to operate a 24 month rural economic development project. The target population is public assistance recipients in a rural area who have the potential for self-improvement or for operating very small businesses, but who are too small financially to qualify for help from the usual sources of assistance (banks, JTPA, SBA, etc). The approach Accord proposes to use to launch their potential entrepreneurs is to assume temporary control of the budding businesses so that the entrepreneurs, as CAA employees, can qualify for JTPA training and stipends they otherwise would not be eligible to receive. Some of the income generated by the small businesses will then be put into a revolving loan fund which can be used to eventually finance other businesses. The partnership element is very strong. Seven public and private organizations making up the Allegany County Training Consortium will work closely with the applicant.

2. NEK-CAP, Inc., Hiawatha, Kansas

The applicant received $249,650 to operate a 24 month project aimed at greatly increasing, with a good cost-benefit ratio, the self sufficiency of families on public assistance. The partnership is unusual. The Kansas CAA will be working in tandem with a CAA in Oregon, the Yamhill County CAP. Both CAAs will be testing the ame hypothesis --- namely, that an integrated, comprehensive case management pproach will enable families to become self sufficient within an average of 16 months at an average cost of $850 per family. The expectation is that out of 482 families served, 296 will become self sufficient by the time the project is completed. One CAA will be testing the use of regular CAA staff as caseworkers while the other will use volunteers. Both CAAs will use a common evaluation methodology and third party evaluator. Both CAAs have also formed strong partnerships with their respective state departments of human resources and with private sector organizations.

3. Central Vermont Community Action Council (CAC), Inc., Barre, Vermont

The applicant is receiving [redacted] $211,175 for a 19 month project aimed at promoting individual, family and small group entrepreneurships among poor people living in rural areas throughout the State of Vermont. Statistics for Vermont indicate that 85% of all employed persons work in a business with fewer than 9 employees and 55% in a business with fewer than 3 employees. Although the general problem is very similar to that addressed by Accord (Applicant #1 above), there are very significant differences between the two projects. Unlike Accord, CAC will be depending for venture capital on a state-administered revolving loan fund. The staff of a state-wide consortium assigned to each of seven CAAs will act as the link between the fund and the potential entrepreneurs, packaging their requests for loans and providing them with the T&TA needed to ensure the success of the ventures. CAC will be seeding businesses in very sparsely populated rural areas while ACCORD will be testing interventions is a more densely populated rural area.

4. City of Phoenix Human Resources Department (HRD), Phoenix, Arizona

The applicant is a public community action agency which is receiving $248,827 for a 24 month project aimed at reducing welfare dependency among adolescent parents. The hypothesis being tested is that a principal impediment to self-sufficiency among the poor is the welfare system itself --- the bureaucratic tangle of multiple, uncoordinated cash and service programs --- and that the degree to which this is ue can be measured through client outcomes when systemic barriers are identified and either removed or bypassed. Not only is this proposal unique among the five recommended for funding in that it is the only one to frontally address the welfare system, but it enlists as partners in the reform effort, the very bureaucracies -- the city and state public assistance agencies -- which are a part of the problem. HRD is a large urban CAA whose clients are mostly black and Hispanic. The experimental groups for this project will be 100 adolescent welfare mothers and the caseload per staff worker will be small: 15 parents per caseworker at any one time. The partnership between the CAA and the state agency (the Department of Economic Security) is strong and well detailed, the match is excellent and the evaluation component extremely well designed. If this project succeeds, it can have a deepening impact on welfare reform efforts thorughout the nation and on the key role CAAs can play in these efforts.

5. Southeastern North Dakota Community Action Agency, Fargo, North Dakota

The applicant is receiving $180,000 for a 24 month project -- "Project Self-Reliance" -- to be carried out by a statewide consortium of the State's seven CAAs, in partnership with several key state agencies. The project calls for 17 CAA staff (self reliance coordinators) to work closely with 300 AFDC households, with the expectation that by the end of the grant period 60 of the 300 households will have come fully self-sufficient, while 200 of the remaining 240 households will have made major strides toward self-sufficiency. The State JTPA is committed to train 50 project clients and there is exceptionally strong State support, from the Governor's office on down, with a State pledge to fund a longitudinal (five year) study of project outcomes. The project, if successful, should furnish a new model for an aggressive CAA role in welfare reform, and mental health care for the poor with CAAs organized on a statewide basis.

Senator HARKIN. David, thank you very much for your testimony. We appreciate it.

I am sorry. We are going to have to recess the subcommittee hearing. I have only about 4 minutes to make a vote. I guess Senator Chiles will be back to Chair the hearing.

Doug Bennet is next. Sorry I could not stay.

[A brief recess was taken.]

STATEMENT OF DOUGLAS J. BENNET, PRESIDENT, NATIONAL PUBLIC RADIO

Mr. BENNET. Mr. Chairman, how are you?

Senator CHILES [presiding]. Fine, Mr. Bennet. How are you?

Mr. BENNET. Delightful. I am delighted to be here. I am happy to have the chance to just say a few words about public radio. My other public broadcasting colleagues are coming along behind me, and they can answer hard questions. I would be happy to answer anything I can.

Let me just make a couple of points about the appropriations request we have before you. One is that this is part of a mosaic of State, local, individual, Government, university, private funding for public broadcasting. It is an extremely important piece of the puzzle. We are looking at an appropriation request in 1991 of $304 million, as you know.

Public radio's purposes for this money would be three. One, is to reinforce the existing stations that we have.

Second, is to increase the number of stations that we are able to serve so that we can reach more audiences, more diversification.

The third element is replacement of the public radio satellite which, as you remember, Congress supplied public broadcasting with its first one years ago.

The satellite is an extremely important, special item this year. The satellite market is such that we may need to be making decisions as early as the fall of 1989 on replacement. So the money that we are requesting here, knowing what we can count on as soon as possible, is critical to making that replacement in an efficient way.

PREPARED STATEMENT

In my prepared statement, Mr. Chairman, there is a great deal of detail about an enterprise that we are very proud of and which I think is serving the country well.

I would be happy to answer any questions I can.

[The statement follows:]

STATEMENT OF DOUGLAS J. BENNET

Mr. Chairman it is a pleasure to be here today on behalf of National Public Radio and its over 350 member stations to testify in support of FY 1991 appropriations for the Corporation for Public Broadcasting (CPB) and for replacement of public radio's satellite interconnection system. An appropriation of $304 million for CPB and $200 million for replacement of the satellite interconnection system will help public radio fulfill its mission of continuing to build an informational and cultural service for our country and expanding service to all Americans; it will also ensure that the national programming in which you have invested continues to efficiently reach listeners across the country.

The public radio system has met the challenge presented by Congress 20 years ago in the Public Broadcasting Act to bring quality, alternative programming to the American people. There are now 301 CPB qualified public radio stations in 49 states. Those stations, all connected by satellite, can be heard by 82% of the population of the United States and serve 11.2 million listeners a week with news and information, cultural and public affairs programming, and programming targeted to minority audiences.

Public radio is a remarkable partnership of federal, state and local governments, universities, foundations, corporations and individual listeners, all acting together to support quality programming which would not otherwise be available in our country. Public radio's support is now about half private and half public. In FY 1986, close to one million individual listeners voluntarily contributed $46 million, 20 percent of public radio's revenue, to their local stations. Listeners have now become our largest single source of support. The federal contribution through CPB is now about 15 percent of station income, and is the bedrock contribution which enables stations to multiply support from other sources and support the quality national programming which has become our hallmark.

New initiatives made possible by funding from the Corporation for Public Broadcasting include: a new national documentary series, SOUNDPRINT, produced by WJHU in Baltimore, which provides funding and state-of-the-art facility and production assistance for works of accomplished and emerging independent producers; GOOD EVENING, the new live entertainment program produced by Minnesota Public Radio and distributed by American Public Radio; and Saturday and Sunday morning

WEEKEND EDITION which makes NPR's news and information programming a seven-day-a-week, morning and afternoon service.

Over the last three years public radio has reasserted its leadership role in creating a national awareness of American cultural treasures in music and drama. PERFORMANCE TODAY, the collective product of many contributing stations and independent producers working through NPR's national production team, provides a nationwide audience for local performances and arts events, including summer music festivals in Cabrillo, California and Rockport, Maine and events like the LA Festival, a major international gathering of artists in all disciplines.

This year NPR began distributing the Latin American News Service (LANS), produced by KXCR-FM in El Paso, and the National Native News Service produced by Alaska Public Radio. In addition, NPR's Department of Specialized Audiences produces and acquires programming by, for, and about ethnic and social minorities -- Black Americans, Native Americans, Pacific and Asian Americans, women, children, the elderly and disabled persons. Approximately ninety percent of this programming is produced by minorities and/or women.

Local stations are providing important services to their communities:

- Connecticut Public Broadcasting, in cooperation with a New England research firm, has recently produced a major, statewide study called CONNECTICUT VIEWPOINT 1988. This huge ascertainment project, which solicited information from residents, business leaders, and state legislators regarding home, work, and life in Connecticut, can be used to stimulate discussions among community leaders, public office holders and Connecticut residents in preparation for the challenges of Connecticut's future. Connecticut Public Radio is facilitating those discussions with a two-week daily series of "town meetings" airing this spring which features public officials and the researchers who conducted the study.
- The Native American villages of Hydaburg and Klawock and the town of Craig on the west coast of Prince of Wales Island in Alaska rely on the translators of public radio station KRBD in Ketchikan, AK for tsunami warnings and Job Service information. There have been four tsunami warnings in the past year-and-a-half; KRBD's translators are the only radio signals (commercial or non-commercial) serving the area and are the only source of such information. KRBD's daily broadcasts of job listings have been found by the area Job Service office to be the most effective way

to serve the employment needs of employers and employees in the remote areas served by KRBD and its translators.

- Public affairs programming at WFSU in Tallahassee, Florida includes "Capitol Report", a daily half-hour program covering the state legislature; a new state-wide hour long call-in program to air this month whose first guest will be Senator Bob Graham; and the only continuous coverage of election returns in their market.
- In San Diego, Hispanic audiences are served by KPBS's 15 hours per week of Spanish-language programming. The three-hour, five day per week programming includes translation of San Diego news, national and international news and music.

Public radio has three goals for the additional funds we seek. All three of these goals build from the success we have had in creating the grass roots based public radio system we know today. The goals are 1) to reinforce the existing CPB-qualified stations to assure that they continue to strengthen both their local and national services to their communities; 2) to reach unserved and underserved audiences with diversified services by increasing substantially the number of noncommercial stations qualified for CPB support; and 3) replacement of the public radio satellite interconnection system.

We recommend increasing the CPB share of station support from 15 percent to 25 percent. At a time of increasing media homogenization across the country, strong, independent local public radio stations, providing a vibrant mix of noncommercial local and national programming, are valuable national assets. Many more Americans, including the elderly, ethnic minorities, children and the handicapped can be better served by public radio if we can substantially increase the number of CPB qualified stations. The same kind of partnership, and the same combination of national and local programming that has made the existing system successful will work for the expanded system.

One final word about system expansion and diversification; the satellite interconnection system will be pivotal in the future as it has been in the past. Radio's unique amalgam of national and local programming would not exist without the satellite. The satellite system is the pipeline connecting major national producing and distributing organizations and hundreds of independent producers with public radio stations and audiences throughout the country. The interconnection system permits public radio to transmit multiple streams of programming to a greatly expanded system and provide both programming of mass appeal as well as programming targeted to individual communities of interest.

The projected life of the present public radio interconnection system ends in 1991. In 1987, the system linked together approximately 250 program suppliers with more than 300 public radio stations. In addition, more than 20,000 hours of public radio programming was transmitted over the system.

The public radio satellite system currently includes 20 satellite uplinks for transmitting programming and 289 receive terminals, or downlinks, located at public radio stations throughout the country. Programs are distributed 24 hours a day, 7 days a week, over a transponder on the Westar IV satellite.

The fundamental characteristics of the existing satellite distribution system remain sound and will form the core of the future system, although a certain amount of refurbishment and replacement of aged equipment will be required for cost-effective and efficient operation.

The future system will also need the flexibility to incorporate adaptations of new technology to accommodate the evolving needs of users of the public radio distribution system. Digital formats are being explored for improvements in audio quality, and efforts will be made to increase the speed and efficiency of communications with stations and improve operating data support systems.

Providers of satellite capacity are predicting sharp increases in satellite prices as availability decreases. Recent estimates show that broadcast demand for satellites will grow 6-8 percent each year for the next decade. Some firms are reluctant tc commit to building new satellites until they have signed contracts for the bulk of available transponders. Given this new environment, we will need to begin making firm commitments to vendors as early as 1989. The probable costs estimated by Touche Ross for public radio's interconnection system are as high as $65 million.

Mr. Chairman, we believe that the public radio system, with its unique combination of distinguished national programming and local involvement, coupled with its vision for the future, merits continued support. We urge the subcommittee to fund the Corporation for Public Broadcasting at the levels in the pending authorization bill: $304 million for FY 1991 plus $200 million for replacement of the satellite interconnection system.

Senator CHILES. Doug, our problem, of course, is how are we going to get by this year with the squeeze that we have in funds. You are kind of coming at us from two directions. One is the increase, of course, in your regular appropriation. The other is this satellite replacement funding, which is a forward funding situation and will not show up until later.

How much do you have to have this year to get that started?

Mr. BENNET. I am talking about just our share of the amount. We have asked for $200 million. I do not think we know precisely the amount——

Senator CHILES. You are tacking onto what will be the other——

Mr. BENNET. I am sorry. The $304 million is the appropriation for operations at CPB, and $200 million additional is for the satellite replacement.

Senator CHILES. Right. Is the satellite just a radio satellite? You said your share.

Mr. BENNET. The way it is working now is that there is a satellite with several transponders. One of the transponders is a radio transponder. Several others are for television.

We are now in the process of refining what the needs are for the future, given the technological changes that are occurring.

Our anticipation is that we are looking at a cost of about $200 million for replacement of the whole interconnection system. Recognizing the pressures that are on you, if we know that the money is there, there probably are ways to stretch it out. If we know that the appropriation is there, we probably could stretch it out.

We have to make a downpayment, in effect, as early as 1989. The question is how much certainty we have for the appropriation.

Senator CHILES. But if you had some kind of a commitment from the Congress, you could go forward with the project?

Mr. BENNET. The authorization alone would help. It requires an appropriation commitment.

Senator CHILES. So you do have to have an authorization for this?

Mr. BENNET. The authorization is pending in S. 2114.

Senator CHILES. So it has not been passed by either now?

Mr. BENNET. Not yet.

Senator CHILES. Well, that is going to give us problems if you do not have something passed on your——

Mr. BENNET. We are hopeful that we will be able to get the bill passed, and we recognize that problem.

Senator CHILES. It is a pretty big jump, of course, from $232 million to $304 million in your operating moneys.

Mr. BENNET. It would carry us up about $20 million in public radio. Recognizing the pressures that are on you, I think we have to have a pretty good reason to justify that.

There are two justifications in our mind. One is that the stations that are now in existence will soon be fighting to maintain their local programming. The economies of radio at this point are enormous. You can have a single central satellite feed and run your local broadcasting operations. So one of the objections here is to buttress the local stations.

The second is to increase our reach. Radio is a highly segmented medium, which means that if you have a station in a market and there are 20 others and you are trying to reach a specific group of people, there are a lot of important public needs of minorities and various other parts of the population that could be met if we could use more stations efficiently. They are there, they are licensed, but it is a question of bringing them on screen.

That is the case. I offer it respectfully and recognize the pressures that are on you.

Senator CHILES. We thank you for your appearance.

Mr. BENNET. Thank you, Senator.

STATEMENT OF ARNOLD D. WALLACE, GENERAL MANAGER, WHMM, WASHINGTON, DC (HOWARD UNIVERSITY), AND SECRETARY, BOARD OF TRUSTEES, NATIONAL ASSOCIATION OF PUBLIC TELEVISION STATIONS

Senator CHILES. Now we will hear from Mr. Arnold Wallace, the general manager of WHMM in Washington, DC, speaking for the National Association of Public Television Stations.

Mr. WALLACE. Good morning, Senator Chiles. First of all, I want to thank you on behalf of public television stations for your strong show of support for participation in the recently concluded annual meeting here in Washington, DC.

I am the general manager of WHMM-TV at Howard University here in Washington and also Secretary to the Board of Trustees of the National Association of Public Television Stations, which is pleased to provide testimony in support of full funding for the Corporation for Public Broadcasting, CPB. I will cover some of the same ground that has been covered before with Mr. Bennet, but I think some of these points need reiterating.

The bills pending in the House and the Senate currently would extend CPB's authorization through fiscal year 1993. For fiscal year 1991, both bills would provide $304 million. In addition, both bills would authorize $200 million to be spent over a 3-year period to replace public broadcasting's aging satellite system.

We endorse full fiscal year 1991 funding for both the station and program support, funds for CPB, and for satellite replacement.

If the best use to be made of the television medium is the investment of millions of dollars to inform the public of differences in laundry detergents and deodorants, then we have missed the most challenging opportunity of the century, the opportunity to provide broad public education to our citizens in a cost-effective manner.

Today, public television provides the only full schedule of broadcast programs for America's children in their homes and classrooms. Programs for children and families like "Wonder Works," "Sesame Street," "Reading Rainbow," and "Square One TV" are indicative of public television's value.

Private studies have shown that children who watch public television's educational programs develop better reading skills than those who do not. Every day public television teaches millions of elementary and secondary students with in-school instructional programming that has brought science labs and foreign language classes to the most rural school districts.

In addition, we teach the nontraditional learners, the adults who are learning to read, working toward their GED, high school equivalency or college degree programs. I am proud to say to WHMM-TV in conjunction with the District of Columbia this past year has launched a major GED program that covers not only the District but also the four surrounding counties.

Public television generally has a proud history of producing television programs that are concerned with social, educational, and community issues.

We believe that after 20 years, it is time for all of us to renew our commitment to public broadcasting's public policy objectives. We believe that commitment of the past 20 years has yielded a strong return on investment and that public television can make an even stronger contribution to ensure America's competitiveness.

For these reasons, we have requested that the Congress through reauthorization of CPB, No. 1, increase the level of support for industry's current services; and, No. 2, replace the aging public broadcasting interconnection system. A crucial hardware need for public broadcasting is the replacement of the interconnect system.

The current system allows for the simultaneous distribution of programming from a number of sources to public television and radio stations in all 50 States, Puerto Rico, and the Virgin Islands. The Westar IV satellite used now by public broadcasting will run out of fuel by mid-1991, requiring the acquisition of new satellite capacity.

Most of the existing ground equipment, receive-only dishes at individual stations, will be almost 15 years old by the time a new system can be chosen and installed; therefore, that, too, needs to be refurbished or replaced.

The 20th anniversary of the signing of the first Public Broadcasting Act has given us the opportunity to evaluate our achievements and to help chart our course for 1990. We appreciate the support this subcommittee has shown for public broadcasting and ask that you support the funding level for CPB pending in the current authorization bill.

PREPARED STATEMENT

Thank you very much. If you have any questions, I would be pleased to try to answer them.

[The statement follows:]

STATEMENT OF ARNOLD D. WALLACE

Introduction and Summary

The National Association of Public Television Stations is pleased to provide testimony in support of full funding for the Corporation for Public Broadcasting (CPB).

Bills pending in the House (H.R.4118) and the Senate (S.2114) would extend CPB's authorization through FY1993. For FY1991, both bills would provide $304 million. In addition, both bills would authorize $200 million to be spent to replace public broadcasting's aging satellite system. We endorse full FY1991 funding for both the station and program support funds for CPB and for satellite replacement.

Public television at a crossroad

Recent news reports, government studies and independent books and publications have sounded the call that America is now "in a period of decline" or "a nation at risk" or "culturally illiterate" or "educationally deprived." Candidates for public office cite symptom after symptom of the illness of our society caused by lack of broad public education -- drug dealing on elementary school playgrounds, a national workforce ill-trained to compete in the changing global economy, violence on our city streets whose victims are not yet old enough to vote and lack of compassion for victims of a disease that still has baffled the best laboratory researchers of our health community.

If we are indeed a nation at risk, it is not because we don't possess the tools or the technology or the creativity to bring us back from the edge. The medium of television is the most powerful instrument ever devised for the communication of images, information and ideas. If the best use made of that medium is the investment of millions of dollars to inform the public of differences in laundry detergents and deodorants, then we have missed the most challenging opportunity of the century -- the opportunity to provide broad public education to our citizens in a cost-effective manner.

Public television is at that critical crossroad between the gaping need for excellence in public education and the tremendous capacity that the telecommunications media have to enlighten and inform. The United States government, to its credit, recognized the need for non-commercial broadcasting as early as 1952, when 242 channels were set aside in the spectrum for the exclusive use of non-commercial television.

The nation's public television stations feel confident that the government's trust in their responsibility over the non-commercial airwaves is not misplaced. At the same time, however, we recognize that the needs are greater, that the mandate is broader, and if public television is to approach fulfillment of the public policy objectives set for it, it will require a greater investment than ever before.

The ways in which public television has served its individual viewers and their communities, states and governments with the resources made available to it are nothing short of remarkable. Public television now serves more than 100 million Americans weekly with the MacNeil-Lehrer Newshour, the most objective nightly, in-depth, news program and Frontline, the only regularly scheduled prime time documentary series on television; with an exhaustive series of national candidate debates; with full live coverage and evening repeats of major Congressional hearings; and with the most extensive schedule of regular and special public affairs programs on television, a schedule that includes Washington Week in Review, Firing Line and Eyes on the Prize. On a local level, an overwhelming majority of public television stations have reported sponsorship, production, and carriage of candidate debates, issue forums, and state and local government coverage.

Public television provides the only full schedule of broadcast programs for America's children in their homes and classrooms. Programs for children and families like WonderWorks, Sesame Street, Reading Rainbow and Square One TV are true jewels in public television's crown. Private studies such as one recently released by the University Center for Research in Lawrence, Kansas, have shown that children who watch public television's educational programs develop better reading skills than those who do not. And, a study by the American Library Association showed that children who viewed Reading Rainbow were much more likely to take out library books and read than other children.

Every day, public television teaches millions of elementary and secondary students with in-school instructional programming that has brought science labs and foreign language classes to the most remote rural school districts. In addition, we teach the "non-traditional" learners -- the adults who are learning to read, working toward their GED high school equivalency or college degrees, enhancing their job skills, or otherwise enriching their lives.

Public television helps eradicate the barriers of privilege and makes the treasures of cultural heritage and vitality of our arts accessible to 97% of all Americans, regardless of their means, their education, their social position, or their distance from theaters, concert halls, or galleries. More people watched American Playhouse's presentation of Arthur Miller's "All My Sons" last January than attended all performances of all plays appearing in all of Broadway's commercial theaters for an entire year. Live from the Met's first broadcast of Puccini's "La Boheme" was seen by more people than had attended live performances of that opera since it was first performed.

Public television has a proud history of producing television programs that are concerned with social, educational and community issues. Whether they are national in scope, or local, like WTVS/Detroit's special employment and dropout prevention programs, community social outreach programs have a special and natural home in public television. The Public Television Outreach Alliance has had a significant impact in providing coordinated, national outreach programs that are tailored by individual stations to meet the needs of their communities. Starting with The Chemical People, through three phrases of the landmark Project Literacy U.S. (PLUS) project, and now with Child Care America, public television stations have become valuable community resources in 366 task forces in all 50 states.

Public television stations are not passive local outlets for packaged satellite services and advertising messages originated hundreds or thousands of miles away; they are nonprofit public service institutions with their roots in the community, dedicated to its service. Indeed, with the recent trends in broadcast acquisitions, mergers and buyouts, we may well become the last bastion for truly local control in the broadcast and cable industries.

Public television and needed federal resources

Congress challenged public television twenty years ago to fulfill the missions it laid out for non-commercial, educational broadcasting. Public television has, in its sometimes awkward but always democratic way, gone far toward those missions and goals. While the federal government intended to provide funding equal to 50% of the total amount of non-federal financial support received by public broadcasting entities, public television has, because of the federal incentive, been able to find 80% of its total operating dollars in the non-federal sector.

We believe that after twenty years it's time for all of us to renew our commitment to public broadcasting's public policy objectives. We believe that the commitment of the past twenty years has yielded a strong return on investment and that public television can make an even stronger contribution to ensuring America's competitiveness. For these reasons we have requested that the Congress, through reauthorization of CPB: 1.) Maintain support of our industry's current services; 2.) Support our industry's proposed programming initiatives with the two-to-one matching funding mechanism contemplated by statute Section 396(k) of the Communications Act of 1934, as amended; and 3.) replace the aging public broadcasting interconnection system.

If the federal government were to fulfill these three requests through reauthorization of CPB, the funding level required would be $442 million in FY1991 and an additional $200 million for satellite replacement. Knowing of the tremendous strain on the federal budget, however, we are supporting the funding levels proposed in H.R.4118 and S.2114, the two pending authorization bills. For FY1991, these bills would provide CPB with $304 million. Both bills would authorize $200 million in total for satellite replacement.

In our attempt to provide the Congress's authorizing committees with information on our industry's needs, we examined all of our programming areas and projected the costs of the programs critical to fulfilling our mission to determine what the federal share should be in the coming years. Take, for example, the area of children's instructional programming. The cost-effectiveness of instructional television make it an indispensable part of both education's and public television's future. If an instructional series is produced for $1 million and used for two elementary school grades, it can affect as many as 4.5 million students per year. The amortized cost over the five year life of the series is then as low as $.22 per pupil.

This can be gauged against the current national average per pupil expenditure of about $2,500 per year.

The need in this area for new programs is great; current programs are aging in reruns and are losing their relevancy for their intended audience. Production costs are increasing at a rate outpacing inflation, resulting in fewer and fewer new program hours being produced each year. With only a total $150 million of new funding, public television could provide these new programs at levels of elementary and secondary instruction, as well as offer new programs specially designed for students at risk of dropping out, and investigate new methods of using television technology as an in-school teaching tool.

We've mentioned Project Literacy and other highly successful public television outreach projects earlier as examples of how effective public television stations together and in their own communities can galvanize their resources to affect social awareness and change. With so many issues in need of massive community efforts -- issues like child care, the elderly, drug abuse, teen pregnancy and suicide -- public television is ready and willing to serve the nation. For $15 million per year, public television would be able to continue these efforts by providing two nationally coordinated outreach programs supporting local outreach initiatives.

Critical need: satellite replacement

A crucial hardware need for public broadcasting is the replacement of public broadcasting's programming lifeline -- its satellite interconnection systems. The current system allows for the simultaneous distribution of programming from a number of sources to public television and radio stations in all 50 states, Puerto Rico and the Virgin Islands. The Westar IV satellite used now by public broadcasting will run out of fuel by mid-1991 requiring the acquisition of new satellite capacity. Most of the existing ground equipment -- "receive only" dishes at individual stations -- will be almost 15 years old by the time a new system can be chosen and installed and therefore need to be refurbished or replaced.

Because of the long lead time required to implement a new interconnection system and to build the complementary ground segment, public broadcasting needs a commitment to its next generation of this programming lifeline. In the original 1967 Public Broadcasting Act, Congress charged CPB with assisting in the establishment of an interconnection system to distribute programs to local public television and radio stations. CPB has fulfilled that charge by helping develop the first national satellite distribution systems presently used by public television and radio, by providing funds to help meet the operating costs of those systems, and by helping to establish structural safeguards for system operation. CPB has played an important part in assuring that effective distribution systems for public television and radio have become a reality while respecting the fundamental premise of localism on which public broadcasting was founded.

With the assistance of federal funding, public broadcasting was able in the late 1970's to convert from AT&T land lines to the current satellite interconnection and become the nation's first major broadcast system to distribute its programming via satellite. This efficient, reliable and high-quality system has enabled public television to pioneer in engineering advances as much as it has in programming. By allowing for distribution of programming from a variety of sources, the system has encouraged diversity in program offerings by its autonomous stations. This kind of access, along with the ease and speed with which new stations have been able to hook up to the system, have helped fulfill a fundamental mission of public broadcasting to maintain local control of programming.

The technology of the current system has allowed for such expansive services as the development of the National Narrowcast Service, ideally suited for educational training programs for business and industry, for specialized elementary and secondary school services, for the Adult Learning Service and for data delivery. Moreover, this technology has encouraged public television to expand its audience to the handicapped by pioneering in closed captioning for the hearing impaired and, most recently, special audio enhancement for the blind.

Full funding encouraged for new education telecommunications programs

We support full funding of the new educational telecommunications activities authorized in the new Elementary and Secondary Education Act. The Secretary's Fund for Innovation in Education would provide important funds for telecommunications materials for classroom use and for teacher training.

The authorization of the Star Schools programs promises to provide new regional, multi-state and nationwide satellite-linked systems of telecommunications for education. Many public television stations intend to apply for the $19 million in available funds this year. We urge full funding of the program for FY1989, to continue to fund the needs evidenced by the large number of applications in FY1988.

Conclusion

The 20th Anniversary of the signing of the first Public Broadcasting Act has given us the opportunity to evaluate our achievements and to help chart our course into the 1990's. It is our hope that this Congress will renew and enhance its challenge to the citizens, the corporations, to all the other governmental and private funders of public television to play an increasing role in achieving the public policy interests originally hoped for from this communication medium. It will be through your renewed commitment to this partnership that we will be able to build on the past twenty years and make the best use of the medium that commercial constraints and mass audience appeals will never allow others to do.

We appreciate the support that this Subcommittee has shown public broadcasting and ask that you support the funding level for CPB pending in the current authorization bill.

Senator CHILES. Thank you, sir.

I had a discussion with our last witness, and I think you heard some of that. Our big problem is how we are going to try to accommodate these things.

Basically, we are talking about a 117-percent increase, with the $200 million, and raising the regular funds up to $304 million. There is no way that we are going to be able to do that.

I am a strong supporter, have been and will continue to be. We will see what we can do, but we have more than we are going to be able to digest when we find ourselves in the financial plight that we are in this year. We will do what we can.

Mr. WALLACE. We know your support is there. Thank you very much, Senator.

Senator CHILES. Thank you, sir.

STATEMENT OF EMILY B. SWENSON, SENIOR VICE PRESIDENT OF CORPORATE AFFAIRS, CHILDREN'S TELEVISION WORKSHOP

Senator CHILES. We will hear now from Ms. Emily Swenson, the vice president of Children's Television Workshop.

Ms. Swenson.

Ms. SWENSON. Thank you, Senator Chiles.

I am here to urge the subcommittee to support educational television programming for this Nation's children. Like Mr. Wallace and Mr. Bennet, we ask you, too, to appropriate the full authorized level of funds for the Corporation of Public Broadcasting for fiscal year 1991 and appropriate the full authorized level of funds for the replacement of the satellite network which carries PBS programs around the country.

In addition, we ask you to direct the Department of Education to commit more funds for educational television, particularly in the areas of science and math.

The mission of the Children's Television Workshop is to educate young people through mass communications. Funds from CPB and the Department of Education help our educational efforts in the following ways.

Community service grants from CPB are used by the public stations to pay about one-third of the cost of "Sesame Street" each year. The workshop itself finances the other two-thirds.

The Corporation and the Department of Education have provided funding for our two educational series for 8- to 12-year-olds, "Square One TV," a daily series on mathematics, and "3-2-1 Contact," a daily series on science.

Season one of "Square One TV" was the result of a unique funding partnership among the Government, the Corporation of Public Broadcasting, foundations, and private enterprise. CPB and the Department of Education contributed $3 million each. Last year we requested funding for more programs. CPB and the National Science Foundation have responded favorably; however, so far the Department of Education has not indicated that it is willing to support continuation of the series.

Senator CHILES. Well, I think that they are leaning that way now.

Ms. SWENSON. That will be wonderful news for us.

The education of our children is in crisis. Our reports show a clear and growing need for improved and expanded educational efforts. Educational television can help meet these needs. It is available to everyone. It expands a child's educational day. It costs only a penny per program per viewer, and it can be put in place relatively quickly.

In its first season, "Square One TV," for example, reached almost one-half of the U.S. households with children under 12.

Public television is the only consistent source of quality educational television available for children, and it needs substantially more funds in the years ahead to continue to fulfill this mission.

PREPARED STATEMENT

We understand that these are tough times, as you have mentioned, to urge greater Federal spending on anything, but we do so because of the crucial need to invest in education and our children. Please support full funding for CPB and the satellite replacement project. We are glad to hear that we may get some good news in the near future.

Thank you. I would be happy to answer any questions.

Senator CHILES. Thank you.

[The statement follows:]

STATEMENT OF EMILY B. SWENSON

Thank you for the opportunity to appear before you today. I am here to urge this Subcommittee to provide strong financial support for educational television programming for this nation's children.

Specifically, I want to ask you and your Subcommittee to:

-- support the full authorized level of funds for the Corporation for Public Broadcasting for FY 1991;

-- support the full authorized level of funds for the replacement of the satellite network which carries PBS programs around the country;

-- encourage the Department of Education to commit more funds for educational television, particularly in the areas of science and math.

The mission of the Children's Television Workshop is to educate young people through mass communications. Funds from the Corporation for Public Broadcasting and the U.S. Department of Education help the Workshop's educational efforts in the following ways:

-- Community Service Grants are used by public stations to pay about one-third of the costs of SESAME STREET each year. CTW itself finances the other two-thirds; and

-- Funding has been provided from both CPB and the Department of Education for our two educational series for 8-12 year olds: SQUARE ONE TV, a daily series on mathematics and 3-2-1 CONTACT, a daily series on science.

Season I of SQUARE ONE TV was the result of a unique funding partnership among government, CPB, foundations and private enterprise. CPB and DOE contributed $3 million each. DOE contributions were made available through the National Science Foundation, the Government's lead funder.

Last year we requested funding for more programs of SQUARE ONE TV in order to build on the success of the first season. CPB and NSF have responded favorably. However so far DOE has not indicated that it is willing to support continuation of the series.

We ask you to urge DOE to continue to be a major participant in the funding consortium that is making possible a significant contribution to mathematics education in this country.

Quality educational television offers a practical, cost-effective way to attract children to new opportunities to learn and thereby extend their educational day. The average child in the United States watches some 25 hours of television each week — spending nearly as much time in front of the television set as in school. Educational television offers a constructive alternative to purely entertainment programming which is the only thing available outside public television. Educational television cannot replace school, but it can help children learn and reinforce school lessons.

SQUARE ONE TV and 3-2-1 CONTACT are good illustrations of this point. SQUARE ONE TV in its first season reached almost half of U.S. households that have a child under 12. 3-2-1 CONTACT is seen by more than 10 million households.

Last year the National Science Foundation commissioned a study of home viewers of 3-2-1 CONTACT to determine the impact of the series. The study findings included the following:

-- girls watch as often as boys and minority children watch as often as white children;

-- children with generally low interest in science watch as often as children who profess great science interest;

-- 50 percent of viewers engage in some science-related activity, such as going to a zoo, museum or library, reading, trying an experiment or solving a problem, with another family member after watching 3-2-1 CONTACT;

-- 60 percent of viewers agree that 3-2-1 CONTACT "makes me feel like I could be a scientist when I grow up."

SQUARE ONE TV focuses attention on mathematics, to enthusiastic response from children, parents and educators. Steven Leinwand, Mathematics Supervisor for Connecticut, wrote to us, "It is clear that a critical component in improving mathematics education in the United States is the creation of a more positive attitude toward mathematics and the clear demonstration to an entire generation of youngsters that mathematics is useful, important and fun -- characteristics rarely engendered by school mathematics. In an engaging and exemplary fashion, SQUARE ONE promotes exactly this message."

Although SQUARE ONE and 3-2-1 CONTACT are primarily designed for at home viewing they are also used in classrooms and in informal educational settings. Teacher guides are provided to enhance in-school use of the programs. 3-2-1 CONTACT and SQUARE ONE TV Clubs have been organized across the U.S. with the help of community groups, schools and corporate sponsors, and several of the nation's most innovative science museums have developed special programs and exhibits based on 3-2-1 CONTACT.

Education of our children is in crisis. Learned commission reports, public opinion polls, national and international achievement scores all paint the same picture -- a clear and growing need for improved and expanded educational efforts. And the problems of scientific and mathematics illiteracy go to the heart of this country's ability to compete in the world arena.

Television is not a panacea, but it can help address at least three of the fundamental problems facing education -- accessibility, cost and the long lead time required to institute change in formal educational settings.

Educational television is broadly accessible to almost everyone, whether rich or poor. It is a bargain at about a penny per program per day for each viewer. And quality educational television can be put in place relatively quickly.

CTW strongly recommends full funding for television education as authorized by the Congress in the new Elementary and Secondary Education Act. Both the Star Schools Program and the Secretary's Fund for Innovative Education are important new steps toward giving our nation's classrooms and homes the best that education has to offer. Both 3-2-1 CONTACT and SQUARE ONE TV have been recipients of the Secretary's Discretionary Funds in the past and many millions of young people have been the beneficiaries. These new authorities will provide the Secretary with additional opportunities to continue these and other outstanding education programs.

Mr. Chairman, public television is the only consistent source of quality educational television available for children. Public television will need substantially more funds in the years ahead to continue to fulfill this basic element of its mission.

These are tough times in which to urge greater Federal spending on anything. We do so because of the lack of state, local or commercial alternatives to education through public television, and because of the crucial need to invest in education.

Please support full funding for CPB and the satellite replacement project, as well as direct the Department of Education to provide more resources to harness television in service of education.

Senator CHILES. What kind of data can you give us to show that the education that we do on television is effective and relevant? Let us take math and science, for example.

Ms. SWENSON. I think that the best example is a study that the National Science Foundation commissioned last year for "3-2-1 Contact."

If I could just read you some of the findings, they found that of children who watch the show, about 50 percent of them engaged in science-related activities after watching the show. They went to zoos, museums, and libraries and so on. So that speaks to examples of the motivational interest.

I think that, in addition, we know that "3-2-1 Contact" children take away factual information. I think Mr. Wallace mentioned some evidence for the younger children which indicates that preschoolers who watch "Sesame Street" and other reading programs have shown a significant increase in their reading ability.

I could provide more documentation if that would be helpful for the record.

Senator CHILES. We would like to see that if you could.

Ms. SWENSON. We would be happy to do so.

Senator CHILES. Thank you for your testimony.

STATEMENT OF JENNIFER KNEELAND, MEMBER, YOUTH PARTICIPATION PROGRAM, AUNT MARTHA'S YOUTH SERVICE CENTER, AND REPRESENTATIVE, BOARD OF DIRECTORS, NATIONAL NETWORK OF RUNAWAY AND YOUTH SERVICES, ON BEHALF OF THE ILLINOIS COLLABORATION ON YOUTH

Senator CHILES. Now we will hear from Jennifer Kneeland, the National Network of Runaway and Youth Services.

Ms. KNEELAND. Mr. Chairman and members of the committee, my name is Jennifer Kneeland. I am 17 years old, and I am a participant and volunteer in the program of Aunt Martha's Youth Service Center located in Park Forest IL, which is a suburb south of Chicago.

I am representing the Illinois Collaboration on Youth, ICOY, a membership association comprised of apprximately 100 community-based youth service agencies throughout the State of Illinois.

Aunt Martha's is one of approximately 300 programs funded by the Department of Health and Human Services under the Runaway and Homeless Youth Act.

I have submitted my statement for the record, and at this time I would like to tell a personal story.

In the early stages of my life, I experienced many problems which later led to more delinquency behaviors. It was not until the end of my sophomore year that I noticed a serious change that needed to take place in my life. Yet, a light did not seem to shine in any of the tunnels of life.

In the summer of my junior year, I met up with an old friend of mine who asked me to join an action group called Project Listen. Project Listen is one of the many youth participation programs in Aunt Martha's. This particular project or advocacy is basically a group of students who go to different churches, conventions, and conferences performing plays.

My entire junior year I became intensely involved in Project Listen. Being on stage seemed to generate a new high for me. This is also when Aunt Martha's in general became a base support for someone to talk to and trust. The people there that were at first acquaintances became the best of my friends. You see, it was youth talking to youth. It was youth trusting youth. It was youth empowering youth, and with this I began to see internal growth in myself and more so in that of the advocacy program mainly because we were able and willing to find similar problems among ourselves in which we all thought less threatened.

In the beginning of my senior year I became associate director of Project Listen, and just after the school year began I was employed in Aunt Martha's as a general youth advocate, which entails working with the other youth participation programs such as SIPP, which is students involved in preventing pregnancies; the Student Voice, which is a completely student run newspaper; students for peace; and voter registration, which is the act and promotion of registering students to vote.

Each of these advocacies contained a variety of different people with very special qualities and characteristics. I thoroughly enjoyed dedicating my time and energy to helping my fellow youth.

In February 1988 I was one of four youths from Aunt Martha's to travel to Washington, DC, for a symposium of the National Network for Runaway Youth Services. There, I was elected to the board of directors which I found would be a bigger step toward the aiding of younger adolescents throughout the country.

My life without Aunt Martha's would be incomprehensible. Even though I did not originally go to Aunt Martha's in order to deal with my problems, I sincerely feel that the whole youth participation program within the agency has been a vital stepping stone in my life along with the lives of dozens of other youth.

I consider myself to be a prime example of the importance of youth participation programs. Had Aunt Martha's not been there for me, I would not be here today asking for the continuation to work in partnership with the Congress of the United States, our State and local governments, and our private citizens to complete the vital work which we have already begun.

PREPARED STATEMENT

America's future, our young people, are depending on us. Thank you.

[The statement follows:]

STATEMENT OF JENNIFER KNEELAND

My name is Jennifer Kneeland and I am a participant and volunteer in the program of Aunt Martha's Youth Service Center, located in Park Forest, Illinois, a suburb south of Chicago. Aunt Martha's is a community based agency which provides a comprehensive range of services to young people and their families, including counseling and temporary shelter, which is available through a network of volunteer host homes. I am representing the Illinois Collaboration on Youth (ICOY), a membership association comprised of approximately one hundred community based youth services agencies throughout the State of Illinois.

I would like to speak with you today on behalf of those young people and their families who are in need of the broad range of services provided by ICOY membership agencies in their respective communities. These services are the result of local programs which were spawned from such federal initiatives as the Runaway and Homeless Youth Act, the Jobs Training Partnership Act, specialized foster care, and independent living. There are several common threads which run through the programs and services of ICOY's member agencies. Foremost among them is a commitment to deliver services which are acceptable to clients, within their communities, at the least restrictive level. While adherence to this commitment presents a challenge to those of us service providers in the community to offer creative alternatives, it also enables us to maximize precious resources.

Aunt Martha's is one of approximately three hundred programs funded by the Department of Health and Human Services under the Runaway and Homeless Youth Act. We are part of a de-centralized, coordinated network of agencies which provides an array of services to troubled young people — local and out-of-state — and their families. Aunt Martha's is able to divert hundreds of youth from the child welfare and juvenile justice systems each year through an immediately responsive program of crisis intervention, family reunification counseling, and temporary shelter. We have done so by adhering to the previously mentioned commitment which incorporates the concepts of; client-acceptable services, provided within a community context, at the least restrictive level. The Runaway and Homeless Youth Act mandates that shelter — widely considered to be a basic human need — be an integral component of all its programs. Indeed, the name of the program which Aunt Martha's participates, the Suburban Temporary Housing Project, implies the provision of this service. However, shelter care is, perhaps, the most expensive of services, costing up to one hundred dollars per day, per client. At that rate, only one day of shelter for each of the young people served by the Suburban Temporary Housing Project would exceed the current annual budget for this program. Clearly, bricks and mortar will not enable us to respond to the myriad needs of the thousands of youth throughout the south suburban Chicago area who will need our services each year. It became necessary to search for a creative alternative to bricks and mortar. What we, at Aunt Martha's have developed is a network of volunteer host homes in the south suburban area.

More than ninety percent of the young people served by the Suburban Temporary Housing Project will be reunified with their families, and this will represent a potential savings of millions of dollars to the state in what it might have spent for alternative care and other wardship services for these youngsters. More importantly, stability has been brought to the lives of these families as a direct result of the intervention and support of local agencies. All this is made possible by this federally funded program.

At any given time, Aunt Martha's Suburban Temporary Housing Project has access to approximately twenty beds through its network of volunteer host homes in the south suburban Chicago area. Obviously, this method of service provision is more cost-effective than bricks and mortar. Most importantly, though, it enables young people to remain in their communities, with a minimum of additional disruption to what often is a period of turmoil in their lives and the lives of their families.

But this is only part of the story. The model offered by Aunt Martha's and other federally funded community based programs throughout Illinois, has served as the impetus for the development of widespread state support of local prevention and diversion programs. The Illinois Department of Children and Family Services, through its program of Comprehensive Community Based Youth Services, provides support for a statewide delivery system of local prevention and diversion programs. The Illinois system of Comprehesive Community Based Youth Services greatly enhances the effectiveness of federal support to the state. The target population and the range of services provided under this statewide system is essentially the same as the Runaway and Homeless Youth Act. In essence, through the support of the Runaway and Homeless Youth Act, the federal government has leveraged nearly eight-fold state support for community based services. (Illinois' current formula-based annual share of the Runaway and Homeless Youth Act is approximately $ 1,000,000; the current amount allocated by the state legislature for Comprehesive Community Based Youth Services is approximately $8 Million.) In addition, these local agencies are also able to garner support from local governments, private support such as the United Way, as well as corporate and foundation support. The Illinois Collaboration on Youth has played an integral role in fostering this public-private partnership. It provides the networking, information dissemination, training, and technical assistance, to federally funded runaway centers and other community based youth serving agencies throughout the state. This enhances their ability to provide high quality services to young people in their communities.

Many local youth agencies are involved in breaking the cycle of poverty and dependence which prevails in their communities. While it is no secret that our neighbor, the City of Chicago, contains several areas which are considered to be among the most economically disadvanatged urban areas in the country, a lesser known fact is that Chicago's south suburbs — Aunt Martha's service area — contain several of the most economically disadvantaged suburbs in the country. It is in these areas that the full impact of the Jobs Training partnership Act (JTPA) is felt.

In general, the young people who are served by these community based programs are afforded their first exposure to the world of work. Not only have they never had the experience of meaningful employment, but they rarely come into contact with adults who have had such experience. Perhaps the most effective beginning is to work with the next generation — young people. The Youth Network Council of Chicago, with its Retail Sales and Management Enrichment Training Programs place approximately one hundred and fifty economically disadvantaged young people — hailing largely from those infamous pockets of poverty, the Cabrini Green and Robert Taylor housing projects — in unsubsidized jobs in the private sector. Similarly, Aunt Martha's Youth Service Center in the south suburbs provides employment training and placement to economically disadvantaged younger adolescents, thereby providing socially acceptable alternatives and successfully undermining the sophisticated recruiting techniques of the ruthless street gangs.

It is clear that community based programs offer disadvantaged youth their best shot at a chance to participate in the mainstream of the American economy. For each economically disadvantaged young person who, at the age of twenty years, us diverted from a lifetime of dependence due to their participation in a JTPA program, the taxpayers are saved approximately $300,000 in what would have been the cost of care over the person's lifetime.

Though our community based youth services programs have been successful, the job is not yet done. Unfortunately, we have been unable to extend our helping hand to every young person who could have benefited. We were all stunned by the rash of six teenage suicides in the metropolitan area, over a two week period, last year. We need to find a way to convey to our young people that we understand what they are going through, and that we care very much about what happens to them. We need to make sure that we have the programs in place to reach out and help them.

We need bold new programs to ensure that youth are afforded the best opportunity to become active and productive participants in our society. We need to ensure that programs such as the Runaway and Homeless Youth Act and the Job Training Partnership Act coordinate their respective mandates to provide for programs of specialized foster care and to foster independent living skills --particularly for those older adolescents, aged between eighteen and twenty-one years — who have fallen through the cracks of our child welfare system and now find themselves out in the world, on their own, without the necessary survival skills. Unfortunately, this is closer to the norm than the exception. We must offer a service continuum which provides a climate where such undesirable outcomes are virtually impossible.

The community based youth services providers of Illinois want to continue to work in partnership with the Congress of the United States, our state and local governments, and our private citizens to complete the vital work we have begun. Our young people are depending on us.

Senator CHILES. Where did you go to school?

Ms. KNEELAND. I went to Flossmore High School located in Flossmore, IL. I am still attending.

Senator CHILES. You are still attending there now?

Ms. KNEELAND. I am still a senior. I graduate this year.

Senator CHILES. What motivated you to come before the committee today?

Ms. KNEELAND. Just this last weekend I attended a board meeting for the National Network of Runaway Youth Services, and a man named Dennis Merstein who works with the Illinois Collaboration on Youth asked me if I wanted to testify. I was willing, and I sliced the extra days to come here.

Senator CHILES. Do you intend to go forward with your education in this field now?

Ms. KNEELAND. Yes; I do.

Senator CHILES. Well, you are a very strong witness, and I am delighted that you did come before us. We will certainly look at these programs and see what we can do there.

I am delighted to hear your story. I think that what you say is very true. The best people that can help young people are other young people. They do not want to listen to what I have to say, and I did not want to listen to what someone had to say when I was a young person, and I did not listen. [Laughter.]

But I think that when there are motivated people like yourself and when they are getting a chance to sit down and share—and the biggest problem, I think, with young people to start with is nobody wants to listen to them, no one will listen to them, and so they get so frustrated. I have experienced that very much myself.

So the fact that you can share and that you can help each other, that is true not only with young people but for any people that can sort of share a common problem.

So your testimony is very compelling, and we are delighted you came before us today.

Ms. KNEELAND. Thank you very much.

Senator CHILES. Thank you.

STATEMENT OF THOMAS C. WESTROPP, CHAIRMAN OF THE BOARD, THE NATIONAL PEACE INSTITUTE FOUNDATION

Senator CHILES. Now we will hear from you, Mr. Westropp, Chairman of the Board of the National Peace Institute Foundation.

Mr. WESTROPP. Mr. Chairman, members of the committee, thank you for hearing my testimony concerning an appropriation for the U.S. Institute of Peace. I have a written statement for the record, and I will summarize it very briefly and also make one or two other very brief comments.

I am Thomas C. Westropp, Chairman of the National Peace Institute Foundation. We are not affiliated with the U.S. Institute of Peace, but we are its friend and advocate.

Our foundation originally was called the National Peace Academy Campaign. For many years we worked with members of the Senate and House to create an American institute for studies in conflict resolution.

We have 15,000 members who financially support our own educational programs. Our advisory board includes eminent educators, distinguished clergy, Members of the Congress, and retired high-ranking military.

Speaking on behalf of our foundation, I urge the subcommittee to support the full $8.6 million appropriation requested by the U.S. Institute of Peace.

The Institute made progress during its first year of operation. It began to carry forth the mission mandated for it by Congress. It established operational independence from the executive branch as required by its charter. It structured a staff and acquired an able and distinguished president, former Ambassador Samuel Lewis to provide leadership.

It launched working programs, awarding some $1 million in grants in research on aspects of conflict resolution. It mapped out a project for negotiation training for Government officials to start in fiscal year 1989. These are some of the achievements during the first year.

Now, the administration recommends a reduced appropriation of $3.4 million, an amount inadequate for continuation of the Institute's good beginnings. To reduce the scope of its activities and its capacity for significant progress would indeed be penny wise and pound foolish.

Mr. Chairman, Senators, the Peace Institute was a bipartisan creation, overwhelmingly approved by the Senate. Members of the Appropriations Committee and others in the Senate led the drive for the Institute. You, Senator Chiles, Senators Harkin, Hatfield, Weicker, and Matsunaga were in the forefront.

The Senate championed the Peace Institute because it well recognized the Nation's need for a better perception and analysis for conflict situations and for greater wisdom in resolving them. Surely this need now is as compelling as ever. In our perilous age, an $8.6 million appropriation for the U.S. Institute of Peace is a reasonable investment in the Nation's future.

PREPARED STATEMENT

Finally, may I remind the Senators that initially the peace academy campaign advocated an institution on the level of the service academies with the prestige and influence that such governmental aegis implies. Although the day for that has not arrived, I hope the concept is not forgotten. I hope the seed has been planted in your remembrance and that some day it will emerge and fluorish to our country's great benefit.

Thank you very much.

[The statement follows:]

STATEMENT OF THOMAS C. WESTROPP

Mr. Chairman, Members of the Committee, my name is Thomas C. Westropp, and I am the Chairman of the Board of the National Peace Institute Foundation and former Treasurer of the National Peace Academy Campaign. The Foundation grew out of the National Peace Academy Campaign, which was instrumental in the creation of the United States Institute of Peace.

The Foundation is not officially affiliated with the United States Institute of Peace. We are an independent organization with more than 15,000 members who financially support our activities, and a group of over 50,000 interested citizens who have worked along with Congress to create the Peace Institute over the past twelve years.

I am here this morning to urge the Committee to appropriate the full $8.6 million requested by the Institute. I strongly believe that the $3.4 million appropriation proposed by the Administration is inadequate and insufficient to the needs, programs and importance of the Peace Institute.

Funding the Institute at this level will enable it to fulfill many of the goals mandated for it by Congress. These include:

- conducting empirical and applied research analyzing the issues of conflict resolution, conflict management and peacemaking in ways relevant to those actively working to resolve conflicts and other policy makers;
- conducting theoretical studies of an interdisciplinary or multi-disciplinary nature designed to expand and refine our understanding of the nature of peace and war;
- serving as an important source of support and training programs for those in government, private enterprise and volunteer associations;
- serving as a clearinghouse and disseminating information to the public about peacemaking and

national and international conflict resolution and management.

I don't expect that we will ever do away with war completely. We should always be vigilant and prepared to defend and protect our democracy. However, in order for humanity and our planet to survive, we must be as equally trained and prepared to wage peace as we are trained and prepared to wage war. Through continued research on the paths to peaceful solutions as alternatives to armed conflict, and dissemination of this body of knowledge to a broader base of people, we will be better able to negotiate peaceful settlements. That would be a tremendous contribution to society.

The Peace Institute is an unusual American initiative for world peace. The push for its creation came from citizens at the grassroots, and the leadership in this effort from members of Congress, rather than the Executive Branch. This academic, scientifically-oriented independent research institution, with its Congressional mandate to place a strong emphasis on the interdisciplinary social science of conflict resolution, is an important element in our nation's ongoing efforts -- and leadership role -- toward world peace.

The Peace Institute leads where neither the private nor the conventional public sector can. Its independent status gives it unusual credibility and strength. That independence also means that the benefits of the Institute's research go directly to Congress and the American people, untarnished by political considerations. Appropriate, sufficient funding is the key to maintaining the independence and the credibility of the Peace Institute.

Among the Institute's important accomplishments and programs greatly deserving of continued -- in fact, increased -- support, are:

- independence from the Executive Branch as set forth in the Peace Institute's Charter and fully established during its first year of operation under the leadership of Chair John Norton Moore and its first President, Robert F. Turner;

- a grants program, mandated by its founding legislation and established in 1986-87 when the Institute awarded over $1 million for research in many academic areas related to peacemaking and conflict resolution;
- a fellowship program, mandated in the Institute's Charter and named after former Senator Jennings Randolph, who introduced and worked tirelessly in support of the legislation creating the Peace Institute;
- the Intellectual Peace Map Project, begun in 1987, which will increase understanding of the scope of the conflict resolution and peacemaking process and expand the impact of the Peace Institute in all sectors of society;
- the selection of former Ambassador Samuel W. Lewis as the Institute's new president, whose background as Ambassador to Israel during both the Carter and Reagan Administrations and participation in the Camp David Accords brings to his role as the Institute's President strong leadership and a broad understanding and knowledge of the elements involved in working to find real solutions to protracted and complex conflicts;
- the beginning of a public outreach and education program, requiring an expanded staff and funding commitment;
- an educational project in negotiation training for government officials, slated for initiation in FY 89.

The vision of the Foundation and the National Peace Academy Campaign was of a viable school or "peace academy" to research and teach peacemaking and conflict resolution to government officials and to citizens. The Peace Institute clearly is not that school yet -- but it can be the first step.

The programs the Institute has outlined for FY 89 move more toward the areas of education and training. The Peace Institute, using monies allocated prior to FY 88, instituted its educational program through the use of television. We believe that the use of educational video cassettes with accompanying printed materials has great potential to be a powerful way to demonstrate to teachers, students, decision makers and the general public how conflict management and resolution can -- and does -- work.

We also look forward to a future when the Institute will hold seminars and debriefings for government officials, members of Congress and Congressional staff on what has been learned in the field of conflict resolution and peacemaking, and on what has been learned from conflicts that have been peacefully resolved or managed through negotiation and mediation, so that they may draw on the lessons learned and apply them elsewhere.

The Peace Institute's programs clearly reflect an approach that is vital to domestic and world peace, which is essential to our survival as a civilization. The National Peace Institute Foundation strongly urges the Committee to appropriate funding for the United States Institute of Peace at the $8.6 million level requested by the Institute.

I want to thank the members of this committee, especially Senators Chiles, Harkin, Hatfield and Weicker, for their leadership and support of the United States Institute of Peace since its creation.

Thank you for inviting the Foundation to testify today.

THE NATIONAL PEACE INSTITUTE FOUNDATION

The National Peace Institute Foundation is a not-for-profit membership organization concerned with public education on the use of scientific peacemaking and conflict resolution theory and techniques in international and domestic conflict.

The Foundation was founded in 1982 as the educational affiliate of the National Peace Academy Campaign, a 45,000 member public service organization which led the citizen effort for creating the United States Institute of Peace. Benefits include the Foundation's periodical, the Peace Institute Reporter, which reports on the United States Institute of Peace as well as other national and domestic peace institutes.

The Foundation manages an international computer conference for scholars, practitioners and interested citizens. It is currently developing a multi-media educational program on conflict resolution from the interpersonal to the international level for secondary school students. The Foundation and its members consult with Congress and other government bodies on the United States Institute of Peace and peace education and conflict resolution programs.

Membership in the Foundation includes the option of participating in Regional Councils. The Councils run workshops and seminars teaching practical negotiating techniques. In addition, the councils sponsor educational forums about the development of national peace institutes and conduct public education activities to promote conflict resolution education and training.

All funding for the National Peace Institute Foundation comes from members, tuition fees, private grants and contributions. The Foundation is an independent organization and is not affiliated with, nor accepts any funds from the United States Institute of Peace.

Senator CHILES. Thank you for your testimony.

We note that right now there is not an authorization for the Peace Institute for 1989.

Mr. WESTROPP. That is correct, Senator. There are two bills pending in the Congress but no appropriation legislation.

Senator CHILES. My understanding is that they have not yet been reported from either the House or the Senate. That, again, is going to be very important for us.

Mr. WESTROPP. It is a situation very much like that which existed when the U.S. Institute of Peace was brought into being. It was attached as part of the Defense Authorization Act and brought into being in that manner.

Senator CHILES. I do not think this time it is tacked on to the defense authorization bill.

Mr. WESTROPP. No; I do not think that it is.

Senator CHILES. Well, I hope they will be moving some legislation on it because that is something that we are going to need to have an authorization on.

Mr. WESTROPP. We hope so, too, Senator.

Senator CHILES. Are you satisfied with the board, the makeup of the board? You said good things about Ambassador Lewis.

Mr. WESTROPP. We are very pleased with his appointment, Senator Chiles. We think he is the ideal person to bring this new agency into a position of leadership both in our country and in the world.

Senator CHILES. How about the makeup of the rest of the board?

Mr. WESTROPP. I think that the board could be broadened and strengthened. The people originally appointed to the board all have excellent credentials in this field, but we would like to see a broader board more representative of society than presently exists.

Senator CHILES. We thank you very much for your testimony and your appearance here today.

STATEMENT OF MICHAEL J. DYER, COUNSEL, NATIONAL CENTER FOR TRAUMA AND EMERGENCY MEDICAL SYSTEMS

Senator CHILES. Now we will hear from Mr. Michael J. Dyer, National Center for Trauma and Emergency Medical Systems.

Mr. DYER. Good afternoon, Mr. Chairman. My name is Michael Dyer. I am the counsel for the Charles McC. Mathias National Study Center for Trauma and EMS. I would request that my written statement be submitted for the record, and I will try to very, very briefly summarize that statement with the chairman's permission.

I believe this committee is very much aware of some of the grim statistical data associated with traumatic injury. Approximately 140,000 persons die each year from trauma. This includes auto accidents, falls, burns, drownings, and intentional traumatic injury such as assaults and so forth.

One particularly grim piece of data is that it is the No. 1 killer of young Americans, those Americans under the age of 44. This is to the tune of about $100 billion per year.

Mr. Chairman, there is a twofold solution, though, that is available to address the problem of traumatic injury. The first prong of this twofold solution is preventive efforts, efforts with regard to seatbelt usage, efforts with regard to injury awareness campaigns. This month, for example, Congress has designated as National Trauma Awareness Month. Efforts with regard to antidrunk driving campaigns; we are only too painfully reminded by this past weekend's accident in Kentucky, the bus accident, of the cost to our youth.

However, the most effective preventive efforts cannot completely alleviate the problem of traumatic injury. There must also be a remedial component as well. That remedial component is a good solid emergency medical services system throughout the country. This would include a variety of different components, including communications, prehospital treatment and transport, in-hospital or in-trauma center treatment, and rehabilitation.

Unfortunately, many areas of the country do not have such systems. One of the goals of the emergency medical services community is to effectively establish some sort of a network of trauma care and EMS systems throughout the country.

In order to realize the goal of optimal care for every citizen, we must establish this network. In order to realize this particular goal, also there should be some sort of a Federal recommitment to renew its focus on emergency medical services.

PREPARED STATEMENT

We would urge full funding for the preventive health service block grant, and we would also urge full funding to pursue the recommendations in the "Injury in America" publication published 2 years and through the Injury Prevention Act which was passed 2 years ago as well.

Thank you very much, Mr. Chairman.

[The statement follows:]

STATEMENT OF MICHAEL J. DYER

Mr. Chairman and members of the subcommittee, my name is Michael Dyer and I am the Counsel to the Charles McC. Mathias National Study Center for Trauma and Emergency Medical Systems.

In the last year and a half since designation by the Congress, the National Study Center has been engaged in a number of research initiatives that should be of interest to the committee. Last year the Center published a booklet entitled, "AIDS: A GUIDE FOR EMS". This publication was the first of its kind, explaining risks, precautions and appropriate procedures to be taken by paramedics and other prehospital care providers. Subsequently the U.S. Department of Health and Human Services awarded a contract to the Study Center to sponsor a one day conference on September 28, 1987 entitled "EMTs and AIDS."

The Study Center also published a report documenting EMS response to the January, 1987 AMTRAK train wreck north of Baltimore. As you will recall this disaster resulted in the death of 16 persons and the injury of 175 other people. Included in this document is a chronology of a major EMS system's response to a mass casualty situation and an analysis of each component's performance. Conclusions and recommendations were made which should be invaluable to all EMS systems seeking to prepare for potential mass casualty incidents.

In addition, the Study Center is the situs for the Trauma Information Exchange System or "TIES." Both the report of the General Accounting Office on EMS and the publication, "Injury in America" identified the need for information assembly and management in trauma and E.M.S. The TIES project is constructed to broker published information on trauma and EMS, and accomplish a system of data management by building directories to data bases, organizations and experts in the field. Study Center staff involved with the TIES project have been working closely and coordinating their efforts with the Center for Disease

Control, the Department of Transportation and the National Association of State EMS Directors.

Another function of the Study Center is to demonstrate EMS systems models as requested. Over the past year the Center had several opportunities to host personnel from various EMS systems.

Among clinical initiatives the Center is exploring, are techniques for non invasive diagnostic monitoring on board ambulances and aircraft. Mr. Chairman, much is being done but much remains to be done.

The problem of trauma continues to grow. Despite enhanced efforts at prevention we find the incidence of traumatic injury on the rise. Preventive efforts are crucial and have done much to curb the rate of this increase, but we must continue to realize that a truly comprehensive approach to the injury problem must include a sound remedial component as well. This component is a network of EMS systems. A viable system of emergency medical services relies heavily on coordination of a wide variety of components. To be sure, the sophistication of EMS capabilities has grown tremendously in terms of knowledge of prehospital response, communication, treatment and triage; hospital and/or trauma center care; and rehabilitation. However, we are only on the threshold, and much remains to be examined by way of research and development so that one day this country can boast a national network of EMS systems with state of the art equipment and expertise.

When the Federal categorical EMS program was abolished and activities were folded into the Preventive Health and Health Service Block Grant, local EMS entities fared poorly in competing for block grant funds. Although the situation has improved somewhat, many local providers of emergency medical services continue to experience cutbacks as funds are filtered down to them. This problem is exacerbated by a rise in uncompensated care which has forced a number of trauma centers to close.

Mr. Chairman, the landmark report, "Injury in America" was published by the National Academy of Sciences two years ago. This document helped bring to the public's awareness the fact that despite the staggering toll traumatic injuries take on human life, productivity and potential, federal support for research and programs designed to address the problems has been minimal. For the first three years, the Subcommittee on Transportation Appropriations provided funds through DOT for CDC's efforts to establish an injury prevention and control initiative, and support a number of demonstration grants. Since enactment of the Injury Prevention Act much of the primary responsibility for funding of endeavors pursuant to "Injury in America" is now within the jurisdiction of the Labor, HHS Appropriations Subcommittees.

Mr. Chairman, we should note that the Injury Control Center at CDC is the closest thing we have seen to a federal focus on EMS and trauma since 1981. In order to realize adequately the recommendations of "Injury in America" and the Injury Prevention Act, substantial financial support is needed to support the injury control program now administered by the Centers for Disease Control.

Where comprehensive EMS systems are in place, chances of surviving traumatic injury rise dramatically. The goal of the EMS community is to create a national network of EMS systems so that every American can have optimal state of the art care available. It is only through a renewed federal commitment to trauma and EMS research, training and program development that this goal can be realized.

Senator **Chiles**. Thank you.

We note, as you did in your statement, that the Department of Transportation provided some $6.5 million in funds, but now we see the Presidential request is $1.4 million.

Mr. **Dyer**. That is correct. That is very painfully inadequate, I am afraid. What we are requesting is the full authorized amount of $10 million.

Senator **Chiles**. How much?

Mr. **Dyer**. $10 million, which is under the Injury Prevention Act, Senator Kennedy's legislation from, I believe, 2 years ago.

Senator **Chiles**. Well, you had $7.9 million last year.

Mr. **Dyer**. That is correct, from this committee.

Senator **Chiles**. Are you going to be able to do much for $1.4 million?

Mr. **Dyer**. Indeed not. I am afraid they will not even be able to maintain appropriate staff levels. Current staff level is down——

Senator **Chiles**. Why did the request fall to that level? Oh, I guess that is what it was before but there was just nothing—everybody knows the DOT funds were in there for a short period of time.

Mr. **Dyer**. That is correct, Mr. Chairman. As you will probably recall, your colleague, Congressman Bill Layman from Florida, who is chairman of the DOT Appropriations Subcommittee, has had a very strong interest in the EMS. He originally mandated and requested that there be this "Injury in America" report, which pursuant to that report they appropriated $10 million over the last 3 fiscal years, I believe, with the exception of last year when they had one foot in this committee and one foot in the other committee.

I do not know why the administration is requesting a cut in funds. They cannot even maintain current staff levels at that amount.

Senator **Chiles**. We thank you for your testimony here.

Mr. **Dyer**. Thank you, Senator.

STATEMENT OF DONALD R. COHODES, ADMINISTRATOR, FEDERAL PROGRAMS, BLUE CROSS & BLUE SHIELD ASSOCIATION

Senator **Chiles**. Now we will hear from Mr. Donald R. Cohodes, the administrator of Federal programs, Blue Cross & Blue Shield Administration. I do not know whether I am pronouncing your name right or not.

Mr. **Cohodes**. Mr. Chairman, my name is Donald Cohodes. I am the administrator of Federal programs for the Blue Cross & Blue Shield Association with responsibility for overseeing the association's Medicare operations.

I, too, will be brief this morning. My formal remarks have been submitted for the record.

We want to state for the record that we believe that the administration's request of $1,391,000,000 is sufficient to meet the basic needs of the Medicare contractors. We will be able to pay claims timely with that money and to continue the current service level that we now provide.

This increase is a substantial increase over the prior year. It is a $200 million plus increase, but our program is largely driven by volume. We anticipate and HCFA confirms that we will be facing an increase on the order of 40 million claims next year.

The second largest element that is associated with this request is that we also anticipate a significant increase in funding for payment safeguards. The total funding level for payment safeguards is anticipated to go up on the order of $100 million. This increase will yield a return in terms of benefit dollars protected on a 5-to-1 basis.

The medical review activity is being significantly expanded, and it is hoped that there will be a return on that order of magnitude as well.

Historically, this subcommittee has recognized the need for a strong administrative structure in Medicare and has added dollars to the administration's proposals when these proposals were understated. This year we urge the subcommittee to act again to support the administration's request and to add a general purpose contingency fund.

We are seeking a general purpose contingency fund on the order of $50 to $60 million to account for four factors that are not now reflected in the administration's budget request. The first one is volume.

Again, we are experiencing substantial increases in volume that we had not anticipated. HCFA had estimated that volume would grow this year for part B claims on the order of 9 percent. In fact, we are now growing at 14 percent.

We anticipate that there will be ongoing implementation costs associated with the OBRA legislation of last year and HCFA estimates that that will cost another $20 million. That, too, is not now part of the budget.

As you know, postage costs went up this spring, and postage costs are a significant component of contractor expenses. We anticipate increased costs on the order of $15 million or so to manage the postage.

Finally, there are costs for another item that is not now in the budget. These are the exit costs associated with replacing a contractor that has decided to leave the Medicare program and to handle the transition costs of other contractors.

Prudential Insurance Co., decided about 6 weeks ago that they would no longer participate in the Medicare program. Their exit underscores the difficulty of operating in the Medicare environment. It reinforces the need for adequate funding. There really is no margin for error in the existing budget.

PREPARED STATEMENT

We would urge the committee to support the administration's request and add a general purpose contingency fund on the order of $50 million.

Thank you.

[The statement follows:]

STATEMENT OF DONALD R. COHODES

Mr. Chairman and members of the subcommittee, I am Donald R. Cohodes, Administrator of Federal Programs for the Blue Cross and Blue Shield Association, the national coordinating organization for all Blue Cross and Blue Shield Plans.

The Blue Cross and Blue Shield organization has been deeply involved in the administration of Medicare since the program began. Under contracts with the Health Care Financing Administration (HCFA), our Association and member Plans serve as Medicare intermediaries and carriers responsible for much of the day-to-day administration of the program. These activities include processing claims promptly and accurately, responding to public inquiries, and performing medical review and audit activities to detect fraud and abuse and to assure only proper payments are made. Nationally, the Blue Cross and Blue Shield system handles about 88 percent of Medicare Part A and 64 percent of all Medicare Part B claims.

The Medicare intermediary and carrier contractor structure has served the program and its beneficiaries well over the last two decades. Medicare contractors' administrative costs, expressed as a percentage of benefit payouts, have been extremely low—about 1.4 percent in FY 1988. Administrative costs on a per claim basis have declined dramatically. In 1984, the average cost of processing a claim was $2.65 for Part A and $2.04 for Part B. For 1988, initial budgets for contractors provide unit processing costs of $1.87 for Part A and $1.57 for Part B — a significant reduction. This decline in unit costs has taken place at the same time the functions associated with processing claims have increased.

Moreover, the contractor system has been extremely effective at safeguarding Medicare benefit payments — resulting in savings more then double the size of the administrative budget. In FY 1989, HCFA estimates about $3.5 billion in Medicare benefit savings as a result of activities designed to safeguard the trust funds. Contractors have also been successful in responding to and dealing with beneficiaries and providers and implementing complex legislative, regulatory, and administrative policy changes, all while coping with an ever growing volume of claims.

In past years, we have testified before this subcommittee that the Administration's budget was inadequate and recommended significant increases above the amounts requested by the President. This year we are pleased to tell the subcommittee that after reviewing the President's budget, we believe the Administration's funding request is adequate to pay claims according to legislated time frames and to maintain current service levels to beneficiaries and providers. However, unlike the Administration, we believe a general purpose contingency fund is needed in FY 1989 and urge the subcommittee to again approve such a fund.

The Administration's FY 1989 Budget Request

In our view, the Administration's FY 1989 budget request for Medicare contractors of $1,391 million is sufficient to meet the basic needs of the program and the payment timeliness standards set by the Congress. In FY 1989, the statutory standards require payment of 95 percent of most claims within 25 days, with a special standard of 18 days for claims submitted by participating physicians. In addition, the Omnibus Budget Reconciliation Act of 1987 requires that no claim be paid in FY 1989 before 14 days after receipt.

The Administration's request reflects an increase of $211 million or 18 percent above the total amounts approved by Congress for FY 1988. This recommended increase is needed to: process 477 million claims expected to be received in FY 1989, 38 million — 9 percent — more than FY 1988; cover inflation; and significantly expand medical review activities. I would like to highlight the major components of the budget.

Claims Processing

Claims processing is the core of the contractor function. The contractors' major challenges are to assure that the claims forms are understood and properly submitted and then to process those claims through a myriad of screens and edits to assure that the services are covered and that charges are reasonable. If properly funded, these claims processing activities can result in significant savings to the trust funds through actions to prevent duplicate payments, apply reasonable charge limits, and detect claims for non–covered care. The Administration's request for this function totals $739 million in FY 1989 to process 477 million claims.

Beneficiary and Provider Services

The beneficiary and provider services category includes the funding necessary for contractors to respond to over 29 million written and telephone inquiries from beneficiaries and providers concerning the status of claims and other issues, to conduct hearings and reconsiderations for beneficiary and provider appeals, to encourage physicians to sign-up as Medicare participating physicians, and to communicate with providers regarding legislative and other changes in Medicare.

The Administration's budget request totals $183 million for these services, $22 million above 1988. The increase is necessary to respond to the growing number of beneficiary and provider inquires, to handle requests for reconsideration of initial claims payment decisions, and to meet the new performance standards enacted in the 1987 Budget Reconciliation Act that sets timeframes for processing reconsiderations and reviews.

Payment Safeguards

The payment safeguard category includes such functions as audit, medical and utilization review, and assuring that Medicare is the "secondary" payer whenever some other payer should be primary. Over the last several years, these payment safeguard activities have received a reasonable level of funding and the results have been rewarding. HCFA estimates savings from these activities will reach about $3.5 billion in FY 1989, more then twice the total administrative budget. The payback ratios, in terms of benefit dollars saved versus administrative dollars spent, have ranged from 5:1 to 20:1 based on the type of activities performed.

In FY 1989, the Administration's budget proposes a total funding level of $403 million for payment safeguard activities, $103 million more than 1988. These additional funds will allow contractors to strengthen the Medicare Part B medical review process in order to limit excessive and improper payments, intensify efforts to assure Medicare is the secondary payer whenever appropriate, and increase audits of provider cost reports.

The Physician Payment Review Commission in its March 1988 report to Congress recommends expansion of Medicare utilization review activities to "limit inappropriate use of Medicare Part B services." In order to assure adequate levels of funding for medical review and related activities, the report suggests several actions, among them are: 1) the feasibility of reflecting the savings or costs associated with increases or decreases in administrative resources in Medicare benefit estimates should be examined; 2) incentives for contractors to implement new medical review initiatives should be tested; and 3) multiyear contracts and appropriations for carriers with satisfactory performance should be investigated.

Contingency Fund

For the first time in several years, the President's budget does not request a general purpose contingency fund for unanticipated events. In the past few years, most of the contingency fund was needed to cover unbudgeted costs, including implementation of Medicare legislative changes.

We believe it is essential that Congress again authorize a separate contingency fund for the Medicare contractor program. We recommend that it be set at $50 million, about the same level as provided in previous years. This would assure that, if needed, funds are available to cover higher than expected claims volumes, any new legislation, and the costs of the recent increase in postage which is not incorporated in the President's request. For example, Medicare Part B claims volumes have been significantly higher than expected for the first five months of this year. If this trend continues, the current FY 1989 workload projections, upon which the President's budget is based, will be understated and the contingency funds would be needed in order to meet the additional workloads.

Consequences of Underfunding

Some of the possible consequences of underfunding Medicare contractors in FY 1989 include:

- Failure to meet the 25 day and 18 day payment standards which could result in:
  - A significant increase (on the order of $2 – 3 billion) in Medicare benefit outlays if hospitals return to the periodic interim payment (PIP) system because the payment standards are not met as provided in law.
  - Increased Medicare outlays associated with interest payments.
- Increased erroneous payments as a result of the possible elimination of all or some payment screens and edits not mandated by HCFA.
- Slowdown in claims payment which could cause reductions in participating physicians and in the number of physicians accepting assignment. This could lead to increases in beneficiary's out-of-pocket costs.
- Deterioration of beneficiary services, including diminished telephone service.

Medicare Catastrophic Implementation

The Administration has requested a separate contingency fund of $112 million to implement Medicare catastrophic legislation should it be enacted. Of this amount, $82 million would be for Medicare contractors and the remainder for HCFA administrative costs. HCFA's estimates are based on the Senate version of the catastrophic bill. We believe the Administration's request appears reasonable, but the estimate will change based on the final provisions of the bill. For example, if outpatient prescription drugs are fully phased in more rapidly than proposed under the Senate bill, additional funds may be essential. We recommend the committee reexamine the size of the catastrophic contingency fund once the bill is finalized.

Conclusion

While we believe the President's basic FY 1989 request is adequate, we ask you to approve a separate additional contingency fund for unanticipated events as you have in previous years.

Senator CHILES. Thank you for your testimony.

STATEMENT OF ARTHUR LIFSON, VICE PRESIDENT, EQUICOR HEALTH INSURANCE ASSOCIATION OF AMERICA

Senator CHILES. Now we will hear from Mr. Arthur Lifson, vice president, EQUICOR Health Insurance Association of America.

Mr. LIFSON. Thank you, Mr. Chairman. I appear today as chairman of the Medicare Administration Committee of the Health Insurance Association of America.

The Medicare program has historically been administered on a contractual basis of no profit/no loss, an arrangement which has produced consistently diminishing administrative costs, presently less than 1.5 percent of total Medicare outlays.

The fact that the Federal payments to private contractors on a unit cost basis for administering the Medicare program has continued to come down despite claims volume increases, new complexities in the program and inflation and fixed costs makes the contractors 'record a remarkable one.

We appear here today to comment on the current status of the public/private sector venture and to present our assessment of the administration's fiscal year 1989 budget request.

For the first time in many years, Mr. Chairman, the message I bring today from the contractors is essentially an upbeat one. We are pleased to note that the administration has more realistically projected the financial needs of the program. Funds requested should be adequate to do what is expected of contractors in fiscal year 1989.

The fact that the usual air of impending crisis has been removed from this stage of the annual budgetsetting process is due in great part to the Health Care Finance Administration. In recent months HCFA staff has noticeably improved communications with the contractors. The exchange of vital information, management reports, and data essential for good planning has improved. This has helped HCFA to better understand the problem areas facing contractors, and contractors have also a greater appreciation of HCFA's management objectives.

Funds spent in fiscal year 1988 by the contractors on the activities to protect the Medicare trust funds have once again produced program savings five times greater than their cost. With consistent returns of this magnitude, we strongly support this year's modest increase in program safeguards while wishing the increase was larger. More certainly could be done.

There is one important matter that warrants your specific attention, the need for additional contingency fund in the fiscal year 1989 appropriation. We note with concern that this is the first budget in many years which does not contain funds for unanticipated contingencies. Such funds are needed for the following reasons.

One, last year Congress legislated a number of new program requirements in OBRA. Funds earmarked for this work are inadequate in the President's budget.

Two, we continue to see an unanticipated increase in part B claims volume.

Three, we are almost certain that the $15 million dedicated for postage will be inadequate.

We strongly urge that you add up to $60 million in contingency funds for the 1989 authorization.

PREPARED STATEMENT

We would like to call your attention to one matter that is of grave concern to the companies I represent. While the no-profit nature of the venture between the Federal Government and the contractors has worked well, in recent years the Health Care Finance Administration has changed the budgeting process from a top down rather than bottom up one. We would hope that you would examine that and their market price strategy and its adequacy for meeting the needs of the program.

Thank you, Mr. Chairman.

Senator CHILES. Thank you. We appreciate your testimony.

[The statement follows:]

STATEMENT OF ARTHUR LIFSON

I am Arthur Lifson, vice president of EQUICOR, Inc. - a joint venture of the Equitable Life Insurance Society of the U. S. and the Hospital Corporation of America. I present this statement as Chairman of the Medicare Administration Committee[1] of the Health Insurance Association of America, a trade association representing some 360 insurance companies.

The administration of Medicare has long served as a model for a pragmatic approach to achieving an essential public policy objective through private means. The Medicare program has historically been administered on a contractual basis of no profit/no loss, an arrangement which has produced consistently diminishing administrative costs -- presently less than 1.5 percent of total Medicare outlays.

The fact that the federal payments to private contractors for administrating the Medicare program have continued to come down despite claims volume increases, new complexities in the program, and inflation in fixed costs makes the contractors' record a remarkable one. This record is a tribute to the Health Care Financing Administration, the private sector companies who operate the program, and to the wisdom of the legislators who opted for this novel approach.

We appear here today to comment on the current status of this public/private sector venture and to present our assessment of the the Administration's FY 1989 budget request.

1/ The following HIAA member companies help administer Medicare as carriers and/or intermediaries: Aetna Life & Casualty, EQUICOR, General American Life Insurance Company, Mutual of Omaha Insurance Company, Nationwide Mutual Insurance Company, Prudential Insurance Company, Transamerica Occidental Life Insurance Company, Cooperativa de Seguros de Vida de Puerto Rico, and The Travelers Insurance Company. Each contractor has served the Medicare program since its inception in 1966.

Mr. Chairman, for the first time in many years, the message I bring today from the contractors is essentially an up beat one.

In prior years, our testimony focused on the serious concerns we had for the administration of Medicare caused by the often divergent priorities of HCFA management and contractors. Our main concern usually centered on the adequacy of funds allocated for the basic claims processing functions, the lynch pin to cost effective and efficient Medicare administration. HCFA was often distracted by the micro management of administrative details while not adequately focusing on overall program efficiencies and expenses.

This year, however, we are pleased to note that the Administration has more realistically projected the financial needs of the program. The funds requested should be adequate to do that which is expected of contractors in FY 1989.

The fact that the usual air of impending crisis has been removed from this stage of the annual budget setting process is due in great part to the Health Care Financing Administration. In recent months, HCFA staff has noticeably improved communications with the contractors. The exchange of vital information, management reports, and data essential to good planning has improved. This has helped HCFA better understand the problem areas facing contractors. Contractors also have a greater appreciation for HCFA's management objectives. With one major exception, day to day relations between HCFA and the contractors are improving.

We see this year's budget request as further evidence that HCFA and the Office of Management and Budget better appreciate the impact that effective claims processing has on total Medicare program outlays. Much of the Administration's 18 percent increase in the total contractor budget for FY 1989 reflects an increased investment in effective claims processing and significantly expanded reviews of claims. In our view, this is a wise and long overdue investment of resources.

Funds spent in FY 1988 by the contractors on activities to protect the Medicare trust funds such as hospital audits, reviewing medical claims, and utilization review have once again produced program savings five times greater than their cost. With consistent returns of this magnitude, we strongly support this year's modest increase in program safeguard funds while wishing the increase was larger. More could certainly be done.

There is one important matter that warrants your specific attention -- the need for an additional "contingency fund" in the FY 1989 appropriation.

We note with concern that this is the first budget in many years which does not contain funds for unanticipated contingencies. Such funds are needed for the following reasons:

1. Last year Congress legislated a number of new program requirements in the Omnibus Budget Reconciliation Act of 1987. Funds earmarked for this work are inadequate.

2. We continue to see unanticipated increases in Part B claims volumes stemming in part from reaction to the hospital prospective payment system.

3. We're almost certain that $15 million will be needed just to cover increased postage costs, not forseen when the President's budget was prepared.

We strongly urge you to add a $60 million contingency fund to your 1989 authorization.

I'd like to call your attention to one matter that is of grave concern to the companies I represent.

Our successful record of Medicare administration stems in part from an earlier spirit of joint responsibility shared by the contractors and HCFA . While the no-profit nature of the venture remains, HCFA's desire to engage us in prior consultation and negotiations as a business partner on critical issues is unfortunately on the wane. The most egregious example of this point is HCFA's recent imposition of top-down budget management.

HCFA recently abandoned the budget negotiation process used successfully for the past twenty years, and imposed an arbitrary top-down budget allocation system. HCFA's stubborn adherence to its "market-price strategy" for setting each contractor's annual budget has proven arbitrary and overbearing. We encourage you to investigate the justification for this significant departure from prior practice. Perhaps your review and judgement on this issue could help eliminate the friction we feel. One would hope that the process will not degenerate further with each party attempting to protect their interests before the judiciary.

Thank you for considering our requests. I'd like to offer our assistance to you and your staff should that be useful.

STATEMENT OF MARTHA McSTEEN, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Senator CHILES. Now we will hear from Martha McSteen, the National Committee to Preserve Social Security and Medicare.

Ms. McSTEEN. Thank you, Mr. Chairman. The national committee answers about 1,700 letters a month from the 5 million members and supporters who have questions and comments about their Social Security and Medicare benefits. Their letters reflect our members 'concerns about inadequate service.

The national committee urges the subcommittee to appropriate adequate funds for the Social Security Administration to maintain current staff levels. We believe that reducing administrative expenses to 1 percent of benefits is excessive.

In addition, the subcommittee should hold the agency accountable for improving employee morale and management deficiencies affecting service.

As acting commissioner in 1985, I believed it possible to achieve a staff reduction of 17,000 over 5 years without jeopardizing service. However, we knew at the time that SSA would have to reconsider if additional workloads emerged and/or new legislation required more staff.

Since the time I agreed to the staffing reduction plan, Congress has added responsibilities as part of the 1986 tax reform and immigration legislation, SSA has experienced significant delays in its claims modernization project, and GAO has issued several reports criticizing various management deficiencies, including overstated payment accuracy rates, and the need for stable leadership and better management.

It is a mistake for SSA singlemindedly to implement the 5-year staffing reduction plan given the additional workload and management problems.

SSA can ignore the demoralization of its line managers as revealed in a recent survey only at the risk of further jeopardizing service to the public. For example, based on GAO estimates, approximately 1,287 claimants per work day report unsatisfactory service in the State of Florida alone.

PREPARED STATEMENT

To obsessively reduce administrative funds further will have a continuing negative impact on programs, service and people. Thank you, Mr. Chairman.

Senator CHILES. Thank you very much for your testimony and your appearance.

[The statement follows:]

STATEMENT OF MARTHA McSTEEN

I am Martha McSteen, Senior Legislative Counsel for the National Committee to Preserve Social Security and Medicare. The National Committee answers on average 1,700 letters a month from our five million members and supporters who have questions or comments just about Social Security or Medicare benefits. These letters provide insight into service problems at the Social Security Administration (SSA) and demonstrate our members' concerns about poor service.

My personal interest in SSA service stems from my over thirty-year association with SSA, the last three as Acting Commissioner. In the latter capacity, I respect the Chairman's aversion to micromanaging the agency. But, I am concerned that SSA is failing to respond to management problems arising from staff cuts which will affect SSA's ability to provide adequate service to 38 million beneficiaries and 125 million workers.

> **The National Committee urges the Subcommittee to appropriate adequate funds for the Social Security Administration to maintain current staff levels. We believe that reducing administrative expenses to one percent of benefits is excessive. In addition, the Subcommittee should hold the agency accountable for improving employee morale and management deficiencies affecting service.**

In 1985, I believed it possible to achieve a staff reduction of 17,000 over five years without jeopardizing service. At the time, SSA was committed to making those reductions in a manner that would not disrupt public service and would permit the programs to continue to operate with integrity and efficiency. It was anticipated that with the Department of Health and Human Service's leadership and the Office of Personnel and Management's cooperation, the downsizing could occur. However, we knew at the time, SSA would have to reconsider if additional workloads emerged and/or new legislation required more staff.

As a long-time manager, I don't necessarily agree with every criticism of SSA management, but I consider the recent SSA survey of its managers an important early warning signal. Morale is a serious problem when 67 percent of managers admit they are not "comfortable with the way SSA is managing the downsizing process," 55 percent indicate their employees are not satisfied with their jobs and only 24 percent would recommend SSA to friends as a good place to work. SSA can ignore the demoralization of its line managers only at the risk of further jeopardizing service to the public.

If the narrative comments of supervisors and managers responding to SSA's recent survey are representative, field offices are still having serious recruitment and retention problems, particularly for clerical staff. Last July, the House Government Operations heard testimony that GS-13 and 14 managers perform routine tasks because they couldn't hire sufficient clerical staff.

One manager, seeking to make SSA a better and more productive place to work, offered this suggestion:

> "Get out into the real world and see that, by the loss of people prior to automation, every corner (legal and some not) is being cut. In my office I am forced to put lines (telephone) on hold as I do not have the people to answer them. The supervisor and myself spend 30 to 50 percent of our time on production."

Emphasis on productivity measurements has not improved service. On the contrary, managers report that service has deteriorated along with morale while statistics look better than ever. For example:

> "Employee morale is low because they feel corrupted. They have seen deceit rewarded and integrity ridiculed. . .It is essential that the agency develop better methods of measuring how well we fulfill our mission. Current methods have led to the most elaborate deceptions imaginable. They have resulted in less true productivity, in favor of more apparent productivity. They have yielded statistical results that any reasonable person would know are impossible; or at least, irrelevant."

Oblivious to its service deficiencies SSA proceeds single-mindedly to implement the five year staffing reduction plan. Since the time I agreed to the staffing reduction plan, Congress has added responsibilities as part of the 1986 tax reform and immigration legislation, SSA has experienced significant delays in its claims modernization project and GAO has issued several reports criticizing various management deficiencies at SSA including overstated payment accuracy rates, effects of budget constraints on the disability program and the need for stable leadership and better management. Obviously, earlier plans concerning staff reduction have missed their mark. So it is imperative that your Subcommittee require SSA to present an efficient and reasonable plan to assure that all offices are adequately staffed and that attention is given to personnel policies that impact so heavily on morale and, in turn, service to the public.

SSA apparently is proud that 85 percent of its clients rate service good or very good, even though client satisfaction does not assure that benefits they receive are accurate. But even if these statistics are taken at face value, the National Committee to Preserve Social Security and Medicare is not satisfied with such results. Based on 2.7 million Social Security and SSI claims and post-entitlement actions a month as detailed in a July 1987 GAO report (GAO/HRD-87-103BR, p. 22), SSA makes 32.4 million significant client contacts a year. If 15 percent of those clients are less than satisfied with the Social Security Administration, that means a total of 4.9 million people, or approximately 1,287 dissatisfied SSA clients per work day in your State, Mr. Chairman. Few businesses would be successful if 15 percent of its clients were dissatisfied. We would be surprised if you or your colleagues were satisfied.

The National Committee applauds greater efficiency in the management of the Social Security program or changes to improve service. SSA has greatly improved processing time on recomputations and in many instances telephone service can be more convenient than a visit to a local office for both the client and SSA. But, if personnel at the TeleService Center or the local office do not provide accurate answers or do not take sufficient time to be sure the client has posed the right questions, these changes do not offer improved service. And, as GAO has noted, telephone accessibility continues to be a problem. For example, a National Committee member from Mableton, Georgia, seeking to assist her grandparents who are in their late 80's, reported:

> "Calling Social Security is one of the most straining attempts I have ever made to get general information. First the line was busy the first 15 times I dialed, then a recording answered and put me on hold. I was given some information about filing for SSI. I followed the procedure. My grandparents were denied, their income was too high by a dollar or two. The letter said I should call the Social Security office and request a specific form to appeal. I called the same number as before, went to all the same trouble to reach a human voice, was told I did not want that form at all. I was given different information as to the qualifications for receiving SSI. . .Without going through so much riff-raff, how can one tell if all benefits have been properly calculated and what can be done if they aren't?"

SSA has rewritten its explanatory leaflets and made them more readable. But there are fewer of them and they no longer provide as much information. Four publications the National Committee finds most useful in responding to member questions, including a pamphlet on appealing an SSA decision, have not been reissued. Also missing are *A Woman's Guide to Social Security* and pamphlets discussing the public employee windfall and spouse/survivor offset.

Many disability applicants also are inadequately served because of cutbacks in staff and are put at risk of losing benefits. Mr. Chairman, when SSA prepares informational material for its clients, efforts are made to keep the text within the reading ability of persons with only limited education. Yet, if that same individual attempts to file for disability insurance benefits, he or she now is expected to personally complete and return a complicated disability benefits application. Only in cases of illiteracy, a lack of knowledge of English, or if mental illness is alleged does the claims representative assist in filling out the form. Some of those forms are not being returned. Weeks or even months later claimants come back and attempt to start over. But lack of timely development of medical evidence can result in delays in establishing a disability onset date, costing the disabled individual months of benefits and, more important, resulting in lower monthly benefits because his or her earnings record was not frozen from the time disability actually started.

From one end of this nation to the other, the National Committee receives reports that our members contacting Social Security offices are receiving questionable, if not erroneous, information or are treated rudely. Whether the problem is inexperience, inadequate training, excessive workloads or pressure to complete calls or interviews within time constraints set by management with a stop-watch in hand, the final result is the same. Inaccurate information can cost individuals and families Social Security benefits they are entitled to receive and misunderstandings undermine confidence in Social Security.

Lorene Graves of Reidsville, North Carolina, reports:

> "I am a widow and was sixty years old in June. Prior to my birthdate, I called the Reidsville Social Security office three times to inquire as to when I could draw my husband's Social Security. Each time I called, I was told I had to be sixty-two years old, unless I became disabled to work. December 1987, I made a visit to the Social Security office and talked with Mrs. Perdew. She told me being a widow, I became eligible at sixty to draw my husband's Social Security. I told her the numerous times I called and was mis-informed. I felt justified in

> asking for back pay. Mrs. Perdew said I could only be paid from the time I placed the application."

Mary Dowe of Watertown, New York, did not lose benefits, but administrative delays threatened her with a hardship:

> "I have been having a problem with our Social Security office about my Medicare. I became entitled last August to receive my Medicare card. I have met with nothing but frustrating replies. Congressman David Martin's office has been trying to straighten the matter out. So far they do not have an appropriate answer (2/2/88). They claim I am lost in the computer and when I do receive my card, I will have to pay back to the month I qualified - which will be a hardship for me."

By reading a column in our newspaper *Saving Social Security*, a National Committee member from Randlestown, Maryland, learned that the information she received from her local Social Security office was incorrect:

> "My husband retired at 70. I will be 62 in July 1988. I called the Social Security office in Baltimore and they told me at 62 I would receive 37-1/2 percent of my husband's amount and if I take it at 62, that is the amount I would always receive. They told me I don't get any more when I am a widow, the only thing I'd get is the $255 lump sum. (emphasis hers). Your article said if a husband dies, the wife's spouse benefits would be replaced by widow benefits. Now I'm confused about this as I have been told two different things. Will you please tell me for sure which is correct."

CONCLUSION

As recently as 1985, administrative expenses were 1.2 percent of Social Security benefits. Even at 1.2 percent of benefits, administrative costs are very reasonable. This year the Administration is requesting administrative funds equivalent to only one percent of benefits. Based on direct feedback from National Committee members, GAO reports and SSA's management survey, it is evident that such a request is too small and has been made without sufficient evaluation. Mr. Chairman, it would be a mistake to continue to obsessively reduce administrative funds as a percent of benefits at the cost of jeopardizing service.

Thank you.

STATEMENT OF MARY LOU BARELA, CHAIR, PUBLIC POLICY COMMITTEE, THE NATIONAL NETWORK OF RUNAWAY AND YOUTH SERVICES, INC.

Senator **Chiles**. Now we will hear from Mary Lou Barela, chair of the Public Policy Committee of the National Network of Runaway and Youth Services, Inc.

Ms. **Barela**. Thank you, Mr. Chairman. I am going to deviate from my testimony which has been submitted for the record.

First of all, I would like to say that I concur with and support Jennifer Kneeland's testimony. She is my colleague on the board of directors for the National Network of Runaway and Homeless Youth. I think that Jennifer proves that the dollars in the Runaway and Homeless Youth Act are being put to effective use.

Our request is for a funding level of $32 million for the Runaway and Homeless Youth Act which would allow programs' grants to return to the 1984 level. Last year this subcommittee appropriated $27.25 million for services to runaway and homeless youth. We appreciated this effort and saw it reinforced by floor action in the House and Senate.

Across-the-board funding costs, however, reduced that amount by $1.15 million to $26.1 million in the continuing resolution for fiscal year 1988.

The national network acknowledges and is grateful for the support given to the Runaway and Homeless Youth Act by this subcommittee. Nevertheless, many runaway youth are being turned away from shelters that are continuously overcrowded.

Currently, the Federal Government spends only $26 per runaway youth to provide food, shelter, and counseling. We should not find it surprising, then, that the following is true. Local runaway centers have waiting lists. Each year, grants to existing centers are being reduced in order to fund additional programs.

Average continuation grants have become smaller since fiscal year 1984. Outreach efforts are a catch 22 situation. How do we in good conscience spread the word about our programs knowing that our centers have no available bed space? Programs have been unable to keep pace with inflationary costs. Long-term alternatives are nonexistent for our homeless youth.

Of special note this year are the efforts underway in the House of Representatives to establish traditional living programs for homeless youth. A new part has been added to the Runaway and Homeless Youth Act through its reauthorization that will provide a long-term program for youth who do not have a home.

This new program area is included in H.R. 1801 which is expected to reach the House floor for a vote this month. The authorization for transitional living programs for homeless youth is $5 million for fiscal year 1989. A triggering mechanism is also included in this bill which mandates a funding of current runaway programs at $28 million before the new services can receive funds.

The national network urges this subcommittee to consider the need to meet the $28 million trigger as additional rationale to fund the existing program at $32 million.

We further urge establishing a $5 million set-aside for the transitional living programs for homeless youth.

PREPARED STATEMENT

The national network on behalf of young people and their families strongly recommends the appropriation of $32 for current services of the Runaway and Homeless Youth Act and the appropriation of $5 million as set-aside for the transitional living project.

Thank you. If you have any questions, I would be glad to answer them.

Senator CHILES. Thank you very much. We appreciate your appearance.

[The statement follows:]

STATEMENT OF MARY LOU BARELA

Chairman Lawton Chiles and other members of the Subcommittee: I thank you for this opportunity to testify on behalf of our country's runaway and homeless youth. My position will not only reflect the urgent needs of these young people but also those of their families.

My name is Mary Lou Barela and I come before you representing the National Network of Runaway and Youth Services, a membership organization of over 700 Runaway Centers and other youth serving agencies. I am the Chairperson of the Public Policy Committee of the National Network's Board of Directors.

I am also Chairperson of Western States Youth Services Network, the Regional Network encompassing California, Nevada, Hawaii, Arizona and Guam.

I further represent Hale Opio Kauai, Inc., a program providing direct service assistance to runaway and homeless youth on the island of Kauai in Hawaii.

The organizations I represent, strongly urge this subcommittee to fund the existing programs in the the Runaway and Homeless Youth Act at a level of $32 million in FY 1989.

In 1974, the federal government began to assist runaway and homeless youth through the enactment of the Runaway and Homeless Youth Act. This legislation and the runaway centers provided for under its mandates have reunited many families, provided safe alternatives to the streets, and been a resource for families in crisis. According to the Department of Health and Human Services over three million youth have received services from these programs since 1976.

The effectiveness and success of these programs have been documented in program inspection reports, testimonials from young people and their families, and the amount of community support given to these programs. While the federal government should take pride in the runaway centers, it cannot fully accept the responsibiltiy for their success. The federal share of a runaway program's operating costs accounts for a maximum of 25% to 30% of its total budget.

The federal share, however, plays an important role in a center's budget and often serves to leverage state, local and private contributions. Nevertheless, programs have suffered over the year from cuts in federal support.

Our request is for a funding level of $32 million for the Runaway and Homeless Youth Act which would allow program's grants to return to the 1984 level.

Last year, this Subcommittee appropriated $27.25 million for services to runaway and homeless youth. We appreciated this effort and saw it reinforced by floor action in the House and Senate. Across the board funding cuts, however, reduced that amount by $1.15 million to $26.1 million in the Continuing Resolution for FY 1988.

The National Network acknowledges and is grateful for the support given to the Runaway and Homeless Youth Act by this Subcommittee. Nevertheless many vulnerable youth are being turned away from shelters that are continually overcrowded.

Best estimates indicate one million youth runaway each year. The Runaway and Homeless Youth Act programs sheltered an estimated 80,000 youth in FY 1987 and an additional 229,000 young people and/or their families received onetime drop-in services. An estimated 700,000 youth in crisis are still without assistance. For example, in Hawaii during the last fiscal year, 2500 youth received services and it is estimated that there were 6000 youths in need of services.

Currently, the federal government spends only $26 dollars per runaway youth to provide food, shelter and counseling. We should not find it surprising, then, that the following is true:

1) Local runaway centers have waiting lists.
2) Each year grants to existing centers are being reduced in order to fund additional programs.
3) Average continuation grants have become smaller since FY 1984.
4) Outreach efforts are a "Catch 22" situation. How do we in good conscience spread the word about our program knowing our runaway center has no available bed space.
5) Programs have been unable to keep pace with inflationary costs.
6) Long-term alternatives are almost non-existant for our "homeless" youth.

Of special note this year are the efforts underway in the House of Representatives to establish Transitional Living Programs for Homeless Youth. A new part has been added to the Runaway and Homeless Youth Act during its reauthorization that will provide long-term programs for youth who do not have a home. This new program area is included in the bill H.R. 1801 expected to reach the House floor for a vote by mid-May 1988. The authorization for the Transitional Living Programs for Homeless Youth is $5 milion in FY 1989.

A triggering mechanism is also included in this bill, which mandates a funding of current Runaway programs at $28 million before the new services can receive funds. The National Network urges this Subcommittee to consider the need to meet the $28 million trigger as additional rationale to fund the Part A Programs at $32 million. We further urge establishing a $5 million set aside for the Transitional Living Programs for Homeless Youth.

The National Network on behalf of the young people and their families strongly recommends the appropriation of $32 million for current services of the Runaway and Homeless Youth Act and the appropriation of $5 million as a set aside for the Transitional Living Project.

Consider, if you will, the cost of losing one million young adults to the streets of America. Reaching them is vital to our National well-being. We must be willing to commit more than the $26.1 million now being spent if we are to achieve success with these youth and their families.

STATEMENT OF WESLEY TARPLEY, WASHINGTON OFFICE, NATIONAL DEMOCRATIC POLICY COMMITTEE

Senator **Chiles**. Now we will hear from Mr. Ronald S. Kokinda.

Mr. **Tarpley**. Senator, Mr. Kokinda could not be here today, so he asked me to represent him. My name is Webster Tarpley, and I would like to thank you for the opportunity to testify on issues pertaining to our national health policy.

The National Democratic Policy Committee has consistently advanced policy recommendations on the basis of a firm commitment to the sanctity of human life. Last year at this time the NDPC urged Congress to initiate a biological defense initiative with an included emphasis on the emerging field of optical biophysics, manmoneer spectroscopy, and bioelectromagnetics coupled with a massive upgrading of health care delivery systems, diet and nutritional improvement in order to meet the threat of AIDS and other growing pandemics.

That action is just a vital today. Yet, our national policy is at the present time dismantling health care and institutionalizing euthanasia against our own people. We must honestly assess this lamentable state of affairs in order to speed the adaptation of sane policies.

Over the past decade and a half, the policy set by our Government, in cooperation with the financial powers of Wall Street and the International Insurance Cartel, have undermined the health care delivery system of this country and have imposed a policy of defacto euthanasia.

The excuse for the policies that are tearing down America's health care system and killing increasing numbers of our citizens is so-called cost containment. The architects of medical cost containment say that this country no longer has the resources to finance high technology medical care for the entire population.

But the destruction of health care in America is rapidly reaching a point of no return. Instead of being guided by the scientific research and by those who have dedicated their lives to saving lives, doctors, nurses, and other health care professionals, health care policy today is reduced to an actuarial exercise managed by insurance companies, accountants and federally funded studies which target patients with low statistical rates of survival.

As one such medical economist has said, and I quote, "The ultimate economy in medicine is death."

We are witnessing, Senator, an undisguised attack on the sacredness of human life, the most fundamental precept of American society and Government. It is the mandate of our Judeo-Christian western civilization that society's economic policies be developed to serve and defend the sacredness of the individual human life.

Unfortunately, the congressional Office of Technology Assessment has chosen to join in this assault on American medicine. Their recent study entitled "Life Sustaining Technologies and the Elderly" aims to eliminate antibiotics, tube and intravenous feeding and hydration, cardiopulmonary resuscitation, renal dialysis, medical ventilation, and other techniques as inappropriate treatment at least for some patients.

The point of this study is to totally revamp America's medical system so that the treatment a patient receives is no longer governed by what can be medically done but by policies which identify categories of patients which will receive lifesaving procedures and which will not.

The specific recommendations of the NDPC would be, first of all, to strike all funding for cost containment research and related consultancy since this has a deleterious effect on health care and has begun to absorb a very large amount of the Nation's health care expenditure.

We would second recommend that insurance companies operating in the United States be obliged to open their books to show exactly what profits are being extracted, in many cases at the cost of the lives of our citizens.

PREPARED STATEMENT

We propose these things in order to return our national policy criterion to one based on the sanctity of human life.

Thank you, Mr. Chairman.

[The statement follows:]

STATEMENT OF WESLEY TARPLEY

Thank you, Mr. Chairman, for the opportunity to testify on issues pertaining to our national health. The National Democratic Policy Committee always advances policy recommendations from the basis of a firm commitment to the sanctity of human life. Last year the NDPC urged Congress to initiate a Biological Defense Initiative, with an included emphasis on the emerging field of "optical biophysics" or "bioelectromagnetics," coupled with a massive upgrading of health care delivery systems and diet and nutritional improvement, to meet the threat of AIDS and other growing pandemics.

That action program is just as vital today. Yet our national policy is to dismantle health care and commit euthanasia against our own people. We must honestly assess this horrible state of affairs in order to speed the adoption of sane policies.

HOW 'COST EFFICIENT' MEDICINE IS KILLING AMERICA

Over the last decade and a half, policies set by our government, in cooperation with the financial powers of Wall Street and the international insurance cartel, have destroyed the health care delivery system of this nation and have imposed a policy of Nazi euthanasia as the final solution to the economic crisis. By every measure, the drive to implement euthanasia in the United States is more coldly efficient, and proceeding at a more rapid pace, than the economically induced euthanasia program initiated in 1933 by Adolph Hitler.

The excuse for the polices which are tearing down America's health care system and killing our citizens is 'cost-containment.' The architects of medical cost-containment say this country no longer has the resources to finance high-technology medical care for its entire population. But the destruction of health care in America is rapidly reaching a point of no return. Instead of being guided by scientific research and by those who have dedicated their lives to saving lives, health care policy today is reduced to an actuarial exercise managed by insurance companies and federally funded "studies" which target patients with a low statistical rate of survival. As one such medical economist said, "The ultimate economy in medicine is death."

To sell triage and health care rationing to the general public, a new field of "experts", called bio-ethicists, was bred for the job. Congress put their morality "in trust" to these new experts. When Congress proposes killer health cuts, the economists "research" the cost-effective impact on a targetted patient population and the bio-ethicists then storm the medical arena selling the resultant triage policy as necessary for distributive justice. Using that rationale, starvation and dehydration of unconscious patients is now THE "ethical" thing to do. It was to the ethicists that

Senator Ted Kennedy (D-Mass.) went in 1977 to discuss what "we can't talk about publicly," i.e. denying health care to sick people under a system of national health insurance. As the Senator put it, "The only way to get cost-containment is to pass the national health insurance bill".

This is an undisguised attack on the sacredness of human life, the most fundamental precept of American society and government. It is mandate of our Judeo-Christian Western civilization that society's economic policies be developed to serve and defend the sacredness of the individual human life. But medical cost-efficiency experts now demand that our society's efforts to protect and nurture human life take second place to government balance sheets. In the process, the dignity of our citizens is being trampled, and the right to life for all Americans, along with the medical science that ensures that right to life through new technologies and cures, is being destroyed.

Instead, the bio-ethicists propose a "new ethics for the new medicine" whose philosophical focus lies in the actuarial maxim that life is negotiable. The results of this travesty, as we shall briefly describe here, are killing America.

The fallacy of cost-effective medicine can be demonstrated in the ways it jeopardizes not only the lives of individual patients but also the viability of America's entire hospital system. Medicare's Prospective Payment System bankrupts hospitals, pressures physicians to prematurely discharge sick patients and to dangerously delay admitting elderly patients until they "are sick enough" to pass DRG (Diagnostic Related Groups) criteria.

As overall bed use declined under DRGs, cost-cutters demanded more hospital beds be decertified. Today, they call for still more cuts while citing the country's inability to give health care to our 37 to 40 million uninsured citizens. But it is exactly their policy of gutting our medical facilities which grievously undermines our country's ability to ever treat those millions of patients, or adequately deal with the slightest national medical crisis, let alone the AIDS seige we now face. The results of their handiwork leaves patients waiting 6-7 weeks for operations, or waiting on stretchers for three or four days before getting emergency treatment.

We now have statistical evidence that such stringent rate regulation and certificate of need programs which deny hospitals' purchase of new medical technologies actually cause higher death rates among patients. Newer equipment saves more lives than outmoded technology, and it pays for itself. The cost-cutters' scaple also undercuts future medical-scientific breakthroughs because their policies make it doubtful that such technology will be used, let alone purchased by heavily regulated hospitals. Thus, investors hesitate to launch new research and development projects.

It is also suspected that the longer a hospital loses profits, the higher their patient death rate. Under Medicare, hospital profits are now "below zero," others are operating in the red, still others have gone bankrupt because Medicare and Medicaid ignore the costs of complicated medical treatment for chronically ill or cancer patients.

To accomodate Medicare's oppresive demands for documentation, hospitals faced a 100% cost increase from paperwork alone. Adminstrators canabalized their nursing staff for accountants, form processors and cost-calculating computers. Underpaid, overworked nurses are driven out by the burden of regulatory documentation and expanded patient load--directly leading to a shortage of 600,000 nurses in the year 2000. That figure does not reflect the radical increases of staff needed to care for the tens of thousands ravaged by AIDS or Alzheimer's disease. While the number of patients grow, our hospitals, like the Veterans Administration, will be forced to close whole wards because of lack of nurses.

Too often patients who need assistance with eating do not get it. Instead, they starve. One-third of all U.S hospital patients are malnourished and a half million more face critical complications because of it. Lack of dieticians means more than 60,000 patients die of starvation in U.S. hospitals every year. These budget-induced deaths are not to be confused with patients who are wittingly denied food and water due to some "right"-to-die or "quality of life" judgement.

Health maintenance organizations, market competition and managed health care, including capitation, are also statistically linked to higher death rates. In each case, the patient becomes a profit making asset or a financial risk to the physician or group. Yet, the Health Care Financing Administration (HCFA) is now planning use the fierce cost-cutting weapon called capitation on our vulnerable Medicare patients in which a flat per patient fee is paid to cover all the patient's medical care, tests, hospital admissions, physician referrals or consultations for an alotted time period. Right now a young Michigan mother of two, is suing her Blue Cross HMO specifically for putting her primary physician at financial risk through its "capitated gatekeeper" program. For over two years, the woman complained of horrible pain and vaginal bleeding as her private physician-gatekeeper profited from the tests he did not order and the timely specialist referrals he refused to allow. The patient, already a victim of the much heralded competition, had cervical cancer that had riddled her body and resulted in a radical hysterctomy and other gruelling operations. This is what HCFA has in store for our elderly. No amount of safeguards can make an intrinsically dangerous system safe. Whether for-profit or not, when these systems lose money, they carve deeper for profits and they cut lives.

The Congressional Office of Technology Assessment has launched a heinous massive assault on American medicine. Their recent study, "LIFE-SUSTAINING TECHNOLOGIES AND THE ELDERLY," aims to eliminate antibiotics, tube and intravenous feeding and hydration, cardiopulmonary resusitation, renal dialysis, and mechanical ventilation, as "inappropriate treatment" for some patients. Written by the top euthanasia mafia in the country, the point of this study is to totally revamp America's medical system so the treatment you receive is no longer governed by what can be medically done to save your life but by policies that dictate which catagories of patients will receive life-saving procedures and which do not.

The OTA Advisors assert a patient's treatment will not be based on diagnosis alone, but on what is considered "beneficial" for him. If the chronically ill patient is confused or fuzzy, extending his life by feeding him would not be beneficial. If a cancer patient developes pneumonia, treating him with antibiotics may not be beneficial. "TO IMPROVE COST-EFFECTIVENESS," the Advisors state that feeding be eliminated for patients with "no 'meaningful' existance" or for whom "it is futile or inappropriate". They plan that hospitals will treat only those patients who have a "statistically known probability of survival." Their Malthusian bottom line is this: "The fact that a reliable life-saving treatment exists does not mean that a person who will die without it, has a right to receive it..."

We have not touched on the criminal role played by the medical insurance companies who take orders from the Club of Rome itself. They, too, have authored genocidal economic policies that carve profits from the lives and the soul of this once-civilized nation. All, at the loss of the dignity of every citizen and the committment to the medical superiority that nurtures it.

The NDPC proposals include:

*An immediate suspension of all cost-containment research and consultants who estimate that such research absorbs an astounding 15% of this country's total health care expenditures annually.

*The U.S. is held hostage by the international insurance cartel. To wipe another huge chunk of medical costs and eliminate the totally unfounded need for massive increases in physician liability insurance premiums, we demand that insurance companies operating in the U.S. be forced to open their books to show exactly what profits are bing extracted at the cost of our citizens' lives.

*adopt economic policies that have America reclaim its productive and technological superiority world-wide.

*return our policy making criteria to one based on the sanctity of life.

Senator CHILES. We thank you for your appearance. We will recess our subcommittee until 9:30 a.m. tomorrow when we will continue to hear our public witnesses. Thank you.

[Whereupon, at 12:25 p.m., Tuesday, May 17, the subcommittee was recessed, to reconvene at 9:30 a.m., Wednesday, May 18.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1989

WEDNESDAY, MAY 18, 1988

U.S. Senate,
Subcommittee of the Committee on Appropriations,
Washington, DC.

The subcommittee met at 9:37 a.m., in room SD-192, Dirksen Senate Office Building, Hon. Lawton Chiles (chairman) presiding.

Present: Senator Chiles.

NONDEPARTMENTAL WITNESSES

Senator Chiles. This morning, the subcommittee is going to continue with the second day of our 9 days of hearings with public witnesses, with testimony focusing on programs funded by the Subcommittee on Labor, Health and Human Services, Education, and the 14 related agencies.

During these several sessions, the subcommittee will hear testimony from approximately 225 witnesses. That is the highest number yet to be heard by the subcommittee in a single year.

Because of the large number of witnesses, we have to request that each witness keep their oral testimony brief. You should be assured that your full statement will be included in the printed record.

In order to help us stay on schedule, we are trying to use the green-red light system. When the red light goes on, your 3 minutes have expired, and we will ask each of you to conclude your remarks, so that every witness will have a fair opportunity to be heard.

Congressman John Rooney, who served on the House Appropriations Committee for many years used to counsel public witnesses by saying the amount of money granted will be in inverse ratio to the amount of time that you take to request it. [Laughter.]

With that advice, he never found it necessary to use a red-green light system like we have today.

STATEMENT OF JODI ALPHIN, R.N. M.S.N., NURSING ADMINISTRATOR, BLAKE MEMORIAL HOSPITAL, BRADENTON, FL, ON BEHALF OF TRI-COUNCIL OF NURSING ORGANIZATIONS

Senator Chiles Our first witness this morning is Jodi Alphin, the nursing administrator of Blake Memorial Hospital in Bradenton.

She is going to speak in behalf of the Tri-Council of Nursing Organizations.

Ms. Alphin.

Ms. **Alphin**. Mr. Chairman, I am Jodi Alphin, R.N., M.S.N., nursing administrator of the ACH/L.W. Blake Hospital in Bradenton, FL.

Today I am representing the Tri-Council on Nursing that includes the American Association of Colleges of Nursing, the American Nurses' Association, the American Organization of Nurse executives, and the National League for Nursing.

These organizations are deeply committed to a strong and continuing Federal role in nurse education and research. At a time when our Nation is facing a critical shortage of professional nurses, it is essential that Federal support be renewed and expanded.

There are two important dimensions of the nursing shortage crisis: one, a shortage of registered nurses in hospitals, nursing homes, and other health care settings; and, two, a decline in student enrollment in nurse education programs.

According to a recent American Hospital Association survey of hospital nurse vacancy rates, the national average for 1986 was 13 percent—a 50-percent increase over the previous year.

In addition, the pipeline of potential nurses is drying up. According to the National League for Nursing, enrollment for all basic R.N. programs reached an all-time high, of 250,553 students during the 1983 academic year. This figure plummeted to 180,000 nursing students in the year ending December 13, 1987.

We strongly oppose the Reagan administration's budget proposal, which calls for combining all of health professions assistance into State grants and slashing spending from $210 million to $40 million.

We appreciate the opportunity to present our views and recommendations with respect to nursing research and education programs in the fiscal year 1989 appropriations bill.

For advanced nursing education, we recommend funding at $19.5 million.

For the nurse practitioner and nurse midwifery program, we recommend funding at $19 million.

For special projects, we would like to recommend funding at $15 million.

For professional traineeships, we would recommend funding at $18 million.

For the nurse anesthetists program, we would recommend continued funding at $800,000.

For faculty fellowships, we would recommend $1 million for post-baccalaureate fellowships.

In support for the National Center for Nursing Research, the Tri-Council has strongly supported the national center since its inception in 1986, and recommends a 1989 funding level of $32 million.

In pending reauthorization bills for the National Institutes of Health, special emphasis is being given to a new matching grant program for construction of research facilities.

These funds are urgently needed, and we ask your support for the appropriation of the proposed $150 million that would include funding available for the NCNR.

In terms of new priorities, in view of the acute nursing shortage, additional Federal support to the nursing profession is required. Senator Kennedy has introduced S. 2231, the Nurse Education Reauthorization Act.

We urge the adoption of four new programs that we hope will be included in this year's reauthorization bill. First, a separate nursing student scholarship program for students with demonstrated financial need, who are enrolled in an accredited educational program.

S. 2231 would authorize $10 million for scholarships for undergraduate students in financial need.

Second, we support funding for up to five model professional nurse recruitment centers at a level of $2.5 million.

S. 2231 would authorize a grant program for demonstration of new practice models for services to individuals in long-term care institutions or in need of home care. We would recommend funding for fiscal year 1989 at $2.5 million.

Finally, we recommend funding a new grant program to support demonstrations of innovative nursing practice models in acute care facilities. We recommend funding for fiscal year 1989 at $3 million.

PREPARED STATEMENT

We urge this subcommittee to continue its strong support for nursing education and research in the fiscal year 1989 appropriations bill, and we appreciate your commitment to the nursing profession over the years.

We would be happy to answer any questions.

[The statement follows:]

STATEMENT OF JODI ALPHIN

Mr. Chairman, I am Jodi Alphin, R.N., M.S.N., Nursing Administrator of the HCA/L.W. Blake Hospital in Bradenton, Florida. I am here today representing the Tri-Council on Nursing that includes the American Association of Colleges on Nursing (AACN), the American Nurses' Association (ANA), the American Organization of Nurse Executives (AONE), and the National League for Nursing (NLN).

The four organizations represented before you today are deeply committed to a strong and continuing federal role in nurse education and research. At a time when our nation is facing a critical shortage of professional nurses and when enrollment in nurse education programs is declining at an alarming rate, we must renew and expand the federal support that has been so critical to the nursing community. We also want to express our appreciation to this Subcommittee for its long-term support to nurse education and research.

THE CONTINUING NURSE SHORTAGE

We would like to share with you some recent information describing the nature and extent of the current nurse shortage. It becomes increasingly evident that federal support can play a vital role. There are two important dimensions of the shortage crisis: (1) a shortage of registered nurses in hospitals, nursing homes, and other health care settings; and (2) a decline in student enrollment in nurse education programs.

A recent American Hospital Association survey of hospital nurse vacancy rates found the national average for 1986 to be 13 percent--a 50 percent increase over the previous year. Vacancies appear greatest in critical care areas and in night and weekend shifts.

The recruitment and retention of nurses has become extremely challenging. Some institutions have developed innovative strategies, but without additional resources these efforts cannot be sustained or replicated. In the long run hospitals must not only be able to offer a competitive wage to nurses but also must find ways to improve the nurse practice environment. Substantial payment reductions for hospital services by Medicare and other payers in recent years have limited the ability of many hospitals to maintain or improve compensation for nurse services.

With the passage of the Omnibus Budget Reconciliation Act of 1987 last December, a series of new personnel standards for nursing homes and home health agencies participating in Medicare and Medicaid became law. These new conditions of participation require a registered nurse to be employed full-time and be on duty for eight hours during the day shift seven days a week in a skilled nursing facility and an intermediate care facility. The current shortage will likely result in a large number of nursing homes applying for a waiver from these standards.

The other ominous challenge facing the profession is the decline in student enrollment in nurse education programs. The pipeline of potential nurses is drying up. Annual surveys by the National League for Nursing of all basic RN programs indicate that enrollment in these programs reached an all-time high of 250,553 students during the 1983 academic year. This figure plummeted to 180,000 nursing students in the year ending December 31, 1987.

THE NURSE EDUCATION ACT

Mr. Chairman, as you know, this is not a climate in which the health of the American people would be well-served curtailing federal support of nurse education. Since 1964, the Nurse Education Act has provided critical support for both nursing students and schools. In its FY 1989 proposed budget, the Reagan Administration calls for combining all of health professions assistance into state grants and slashing spending from $210 million to $40 million. We strongly oppose this recommendation.

We would like now to offer our specific recommendations on FY 1989 funding levels for programs now authorized under Title VIII.

Advanced Nurse Education: Grants are available to master's and doctoral programs in schools of nursing to plan, develop, and operate new programs or expand existing programs. We recommend FY 1989 funding at $19.5 million.

Nurse Practitioner and Nurse-Midwifery Program: These grants are available to support full-time programs to prepare registered nurses as qualified primary health care providers. We recommend increased support for these programs and FY 1989 funding at $19 million.

Special Projects: This section authorizes grants to support improved nursing practice with special emphasis on programs aimed at students from disadvantaged backgrounds, innovative programs of continuing education for nurses in practice, and re-training opportunities for those returning to the workforce. We recommend FY 1989 funding at $15 million.

Professional Traineeships: These grant funds are intended to give direct student assistance for individuals enrolled in a master's, doctoral, or midwifery program and preparing for a teaching, administrative, research, or practitioner career. We recommend FY 1989 funding at $18 million.

Nurse Anesthetists: These are direct student aid funds that support nurses pursuing qualification as nurse anesthetists. We recommend continued funding at $800,000 for FY 1989.

Faculty Fellowships: These post-baccalaureate fellowships are available to nursing school faculty enrolled in either a master's or doctoral program to investigate alternative health care delivery or study effective nurse interventions in high-priority health areas. We recommend continued funding at $1 million in FY 1989.

SUPPORT FOR THE NATIONAL CENTER FOR NURSING RESEARCH

We would now like to draw your attention to the work of the National Center for Nursing Research (NCNR) at the National Institutes of Health, authorized under the Public Health Service Act. The Tri-Council has strongly supported the Center since its inception in 1986. Most of the Center's projects focus on analysis of the health care need of high-risk populations, the elderly, the chronically ill, the disabled, and those with terminal illnesses. We recommend FY 1989 funding at $32 million.

In pending re-authorization bills for the National Institutes for Health special emphasis is being given to a new matching grant program for construction of research facilities. The need for these funds is urgent, and we ask your support for the appropriation of the proposed $150 million, that would include funding available for NCNR. Like other disciplines, nursing research programs suffer from inadequate or antiquated space.

NEW PRIORITIES

Additional federal support to the nursing profession is required in view of the acute shortage of nurses. We have been working with members of House and Senate authorizing committees to identify new initiatives targeted to mitigate the shortage crisis. In the Senate, Senator Kennedy has introduced S.2231, the Nurse Education Reauthorization Act. We urge the adoption of four new programs that we hope will be included in this year's reauthorization bill.

First, there is no doubt that federal aid to students pursuing an undergraduate degree in nursing is sorely needed. Many potential nursing students come from economically disadvantaged backgrounds and are simply unable to afford the expenses of higher education. Student loans have limitations arising from the rapidly increasing cost of education and the burden such loans create for a person entering the nursing profession.

We strongly support a separate nursing student scholarship program for students with demonstrated financial need who are enrolled in an accredited educational program. S.2231 would authorize $10 million for scholarships for undergraduate students in financial need. The Tri-Council recommends funding of this critical program in the FY 1989 appropriations bill.

S.2231 also includes support for up to five model professional nurse recruitment centers. The centers are intended to conduct recruitment efforts aimed at individuals in junior and senior high school, those enrolled in college before declaring a major, and adults. We recommend $2.5 million for these centers for FY 1989.

Third, S.2231 would authorize a grant program for demonstration of new practice models for services to individuals in long-term care institutions or in need of home care, with an emphasis on the efficient management of services through patient assessment. We recommend funding for FY 1989 at $2.5 million.

Finally, we recommend funding a new grant program to support demonstrations of innovative nursing practice models in acute care facilities. Such a program would provide an opportunity to replicate the successful experience of those institutions that have high retention rates. We recommend funding for FY 1989 at $3 million for such demonstration grants.

We urge this Subcommittee to continue its strong support for nursing education and research in the FY 1989 appropriations bill. We are grateful for your commitment to the nursing profession over the years, and we look forward to working with you.

Senator CHILES. Thank you, Ms. Alphin. You are right. I do support very much our nurses. I think we do have a shortage and within what available funds we are going to be able to deal, we are certainly going to try to see how we can help.

Ms. ALPHIN. Thank you.

Senator CHILES. Thank you for your testimony.

STATEMENT OF EUGENE MAYER, M.D., M.P.H., DIRECTOR, NORTH CAROLINA AHEC PROGRAM

ACCOMPANIED BY:

STEPHEN B. ZUCKER, D.O., DIRECTOR, SOUTHEASTERN FLORIDA AHEC PROGRAM

ARTHUR FOURNIER, M.D., UNIVERSITY OF MIAMI AHEC PROGRAM

Senator CHILES. Now we will hear from Dr. Eugene Mayer, the director of the North Carolina AHEC Program, accompanied by Dr. Stephen B. Zucker and Dr. Arthur Fournier.

Dr. MAYER. Mr. Chairman, I am Dr. Eugene Mayer, associate dean of the School of Medicine of the University of North Carolina and director of the North Carolina Area Health Education Centers Program, or AHEC.

On my right is Dr. Stephen Zucker of the Southeastern College of Osteopathic Medicine—excuse me; he is on my left—and on my right is Dr. Arthur Fournier of the University of Miami School of Medicine. Both have AHEC projects at their schools.

We are here today on behalf of 27 AHEC projects in 26 States.

We appreciate very much the strong support that we have received from you and this subcommittee.

It is essential that the National AHEC Program continue, and we are actively working to have the program reauthorized. We have proposed a new authority of $26 million for fiscal year 1989, made up of four subsections: $18 million for the basic AHEC program; $2 million for the special initiatives section; $3 million for infant mortality; and $3 million for high impact area support.

Throughout the United States, we continue to attack the problem that led to the establishment of the National AHEC Program, that being the maldistribution of physicians, nurses, and other practitioners in rural and inner city areas. We are making important progress.

In North Carolina, before our AHEC program was established, only 41 percent of our counties experienced an improving ratio of physicians to population. During the following decade, 89 percent of our counties, the fourth most rural State in the Nation, find their ratios improving.

Many other States, including California, New Mexico, North Dakota, South Carolina, and West Virginia are reporting similar successes.

New AHEC programs in Florida, Arkansas, Alaska, Idaho, and other States should eventually help improve the distribution of health manpower.

Although many Americans now enjoy a high standard of health care, many rural and inner city areas still do not have enough health professionals.

The simple truth is that young physicians and other practitioners do not tend to set up practice in rural or inner city areas unless they receive a lot of special attention. AHEC provides that attention.

The AHEC program has evolved into an effective partnership. We have all types of people from the public and private sectors working together in pursuit of a common objective.

In North Carolina, over 30 percent of our State's private physicians regularly teach through this program.

The AHEC programs enable students to take a portion of their training at community hospitals and health centers. The students receive an exposure to practicing physicians. The hope is that some of the young professionals will decide to practice in rural or inner city areas.

In North Carolina, 61 percent of the family practice residents trained in AHEC have remained in the State, and 40 percent of those have located in towns of fewer than 10,000 persons.

AHEC also works with health science schools to offer continuing education to practicing professionals. This not only helps professionals feel less isolated, but also assures that they can keep up to date, even if they practice far from major medical centers.

The University of Miami program links the medical school with six community health centers in underserved areas of Dade County. This brings medical students to the community for primary care education. Also, podiatry and nurse practice training programs are getting underway.

The Southeastern College of Osteopathic Medicine has centers in the Everglades and central Florida, serving some of the most severe poverty areas of our Nation. In its first year, 1,500 weeks of student training have occurred in this underserved area.

Mr. Chairman, the AHEC program has proven to have been a wise investment. This year, over $100 million State and local money complement the $18 million Federal appropriation.

PREPARED STATEMENT

We invite the subcommittee to review the strong endorsements of the AHEC program contained in several national studies. We hope that in the fiscal year 1989 budget, the Congress will maintain its commitment to a program aimed at ending the maldistribution of physicians and health practitioners in rural and inner city areas.

Thank you again for the opportunity to appear.

[The statement follows:]

STATEMENT OF EUGENE MAYER

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM DR. EUGENE MAYER, AND I AM ASSOCIATE DEAN OF THE SCHOOL OF MEDICINE OF THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL AND DIRECTOR OF THE NORTH CAROLINA AREA HEALTH EDUCATION CENTERS PROGRAM, OR AHEC, AS WE CALL IT. WITH ME ARE DR. STEPHEN B. ZUCKER OF THE SOUTHEASTERN COLLEGE OF OSTEOPATHIC MEDICINE IN MIAMI AND DR. ARTHUR M. FOURNIER OF THE UNIVERSITY OF MIAMI SCHOOL OF MEDICINE. BOTH SCHOOLS HAVE AHEC PROJECTS.

WE ARE HERE TODAY ON BEHALF OF 27 AHEC PROJECTS IN 26 STATES THAT ARE RECEIVING FEDERAL AHEC FUNDING THROUGH THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

AS WE HAVE INDICATED IN PREVIOUS APPEARANCES, WE APPRECIATE THE SUPPORT THAT WE HAVE RECEIVED THROUGH THE YEARS FROM YOU AND FROM THIS SUBCOMMITTEE. WE BELIEVE IT IS ESSENTIAL THAT THE NATIONAL AHEC PROGRAM CONTINUE, AND WE ARE ACTIVELY WORKING WITH THE COMMITTEE ON LABOR AND HUMAN RESOURCES TO HAVE THE PROGRAM REAUTHORIZED. IN VIEW OF THE INTEREST OF THE CONGRESS IN INFANT MORTALITY, IN HIGH IMPACT UNDERSERVED AREAS...SUCH AS THE TEXAS-MEXICAN BORDER, AND IN VIEW OF THE DEMONSTRATED EFFECTIVENESS OF THE EXISTING SPECIAL INITIATIVES SECTION OF THE AHEC AUTHORITY, WE HAVE PROPOSED A NEW AUTHORITY OF $26 MILLION FOR FY 1988. WE URGE THE CONGRESS TO AUTHORIZE AND APPROPRIATE THESE FUNDS SO THE PROGRAM CAN CONTINUE TO IMPROVE ACCESS TO MEDICAL CARE IN UNDERSERVED AREAS.

THROUGHOUT THE UNITED STATES WE CONTINUE TO ATTACK THE PROBLEM THAT LED TO THE ESTABLISHMENT OF THE NATIONAL AHEC PROGRAM--THAT PROBLEM BEING THE MALDISTRIBUTION OF PHYSICIANS AND OTHER HEALTH PRACTITIONERS IN RURAL AND INNER CITY AREAS. I AM HAPPY TO REPORT, MR. CHAIRMAN, THAT WE ARE MAKING IMPORTANT PROGRESS.

IN MY STATE OF NORTH CAROLINA, FOR EXAMPLE, DURING THE DECADE BEFORE OUR AHEC PROGRAM WAS ESTABLISHED, ONLY 41 PERCENT OF OUR COUNTIES HAD EXPERIENCED AN IMPROVING RATIO OF PHYSICIANS TO POPULATION. BUT DURING THE FOLLOWING DECADE, 89 PERCENT OF OUR COUNTIES FIND THEIR PHYSICIAN-TO-POPULATION RATIOS IMPROVING.

MANY OTHER STATES WITH AHEC PROGRAMS--INCLUDING CALIFORNIA, NEW MEXICO, NORTH DAKOTA, SOUTH CAROLINA AND WEST VIRGINIA--ARE REPORTING SIMILAR SUCCESSES IN IMPROVING THE GEOGRAPHIC DISTRIBUTION OF HEALTH PROFESSIONALS. NEW AHEC PROGRAMS HAVE BEEN CREATED IN FLORIDA, ARKANSAS, ALASKA, IDAHO, AND OTHER STATES. THESE PROGRAMS SHOULD EVENTUALLY BE SUCCESSFUL IN HELPING TO IMPROVE THE DISTRIBUTION OF MEDICAL MANPOWER.

ALTHOUGH MANY AMERICANS NOW ENJOY A STANDARD OF HEALTH CARE THAT WOULD HAVE SEEMED UNIMAGINABLE TWO DECADES AGO, MUCH REMAINS TO BE DONE. MANY RURAL AND INNER CITY AREAS AROUND THE UNITED STATES STILL DO NOT HAVE ENOUGH PHYSICIANS, NURSES AND OTHER HEALTH PROFESSIONALS. PARTICULARLY DISTRESSING IS THE FACT THAT THIS PROBLEM PERSISTS AT A TIME WHEN WE ARE HEARING A LOT OF TALK ABOUT A POTENTIAL OVERSUPPLY OF PHYSICIANS IN GENERAL. THE SIMPLE TRUTH IS THAT YOUNG PHYSICIANS DO NOT TEND TO SET UP PRACTICE IN RURAL OR INNER CITY AREAS UNLESS THEY RECEIVE A LOT OF SPECIAL ATTENTION. **AHEC PROVIDES THAT ATTENTION.**

THE MALDISTRIBUTION OF HEALTH PROFESSIONALS IS A TERRIBLY DIFFICULT PROBLEM, MR. CHAIRMAN. THAT WAS SOMETHING THAT WE IN THE HEALTH EDUCATION COMMUNITY RECOGNIZED AT THE TIME THAT THE AHEC CONCEPT WAS BEING DEVELOPED 15 YEARS AGO. THE CONGRESS RECOGNIZED IT, TOO, AND PASSED LEGISLATION THAT PROVIDED FEDERAL FUNDS FOR THE NATIONAL AHEC PROGRAM. EVERYONE INVOLVED KNEW WE WERE TALKING ABOUT A TREMENDOUS EFFORT THAT WOULD NEED TO BE MEASURED IN TERMS OF DECADES, NOT YEARS.

THE AHEC PROGRAM HAS EVOLVED INTO AN EFFECTIVE PARTNERSHIP INVOLVING THE FEDERAL GOVERNMENT, STATE GOVERNMENTS, LOCAL GOVERNMENTS, HEALTH SCIENCE SCHOOLS, COMMUNITY HOSPITALS AND HEALTH PRACTITIONERS. THE PARTNERSHIP INVOLVES THE OTHER PRIMARY CARE INITIATIVES OF THE FEDERAL GOVERNMENT, AS WELL. THAT KIND OF COOPERATION SEEMS TO HAPPEN ALL TOO RARELY IN OUR SOCIETY, AND WE WHO ARE ASSOCIATED WITH AHEC FEEL MOST FORTUNATE. WE HAVE ALL TYPES OF PEOPLE FROM THE PUBLIC AND PRIVATE SECTORS WORKING TOGETHER IN PURSUIT OF A COMMON PUBLIC POLICY OBJECTIVE. FOR EXAMPLE, IN NORTH CAROLINA, OVER 30 PERCENT OF OUR STATE'S PRIVATE PHYSICIANS REGULARLY TEACH THROUGH THIS PROGRAM.

THE AHEC PROGRAMS ENABLE STUDENTS AND MEDICAL RESIDENTS AT HEALTH SCIENCE SCHOOLS TO TAKE A PORTION OF THEIR CLINICAL TRAINING AT COMMUNITY HOSPITALS AND HEALTH CENTERS--AN ARRANGEMENT THAT ENDS UP BENEFITING EVERYONE. THE STUDENTS AND THE RESIDENTS RECEIVE AN EXPOSURE TO PRACTICING PHYSICIANS IN A COMMUNITY SETTING--SOMETHING THEY MIGHT NOT HAVE HAD OTHERWISE. THE LOCAL AGENCIES GET THE SERVICES OF HIGHLY QUALIFIED HEALTH PERSONNEL AND THE PEOPLE OF THE COMMUNITY HAVE ACCESS TO BETTER HEALTH CARE.

THE HOPE, OF COURSE, IS THAT SOME OF THE YOUNG HEALTH PROFESSIONALS WHO PARTICIPATE IN THIS COMMUNITY-BASED PROGRAM WILL DECIDE AFTER COMPLETING THEIR EDUCATION TO PRACTICE IN RURAL OR INNER CITY AREAS--THE AREAS WHERE HELP IS DESPERATELY NEEDED. IN NORTH CAROLINA, 61 PERCENT OF THE FAMILY PRACTICE RESIDENTS TRAINED IN AHEC HAVE REMAINED IN THE STATE, AND 40 PERCENT OF THOSE HAVE LOCATED IN TOWNS OF FEWER THAN 10,000 PERSONS.

THE AHEC PROGRAMS ALSO WORK WITH HEALTH SCIENCE SCHOOLS TO OFFER CONTINUING EDUCATION AND TECHNICAL ASSISTANCE TO PRACTICING HEALTH PROFESSIONALS THROUGHOUT THE STATE. THIS SERVICE NOT ONLY HELPS COMMUNITY-BASED PROFESSIONALS FEEL LESS ISOLATED BUT ALSO

ASSURES THEM THAT THEY CAN KEEP UP TO DATE EVEN IF THEY PRACTICE FAR FROM THE MAJOR MEDICAL CENTERS.

I AM HAPPY TO REPORT ALSO THAT AHEC'S AROUND THE NATION HAVE BEEN SUCCESSFUL IN ADAPTING PROGRAMMING TO MEET CHANGING COMMUNITY NEEDS. MAJOR EFFORTS HAVE BEEN UNDERTAKEN TO DEVELOP INTERDISCIPLINARY EDUCATIONAL PROGRAMS IN COMMUNITY SETTINGS IN THE AREAS OF AGING, HEALTH PROMOTION AND DISEASE PREVENTION, AIDS, HEALTH SERVICES MANAGEMENT, COST CONTAINMENT, MENTAL HEALTH, AND QUALITY ASSURANCE.

THE UNIVERSITY OF MIAMI AHEC PROGRAM LINKS THE MEDICAL SCHOOL WITH SIX FEDERALLY FUNDED COMMUNITY HEALTH CENTERS IN SERIOUSLY UNDERSERVED INNER CITY AREAS OF DADE COUNTY. THIS LINKAGE BRINGS MEDICAL STUDENTS TO THE COMMUNITY FOR PRIMARY CARE EDUCATION. ALSO, PROGRAMS IN PODIATRY AND NURSE PRACTITIONERS TRAINING ARE NOW ACTIVE AS IS A PROGRAM TO RETAIN NATIONAL HEALTH SERVICE CORPS PHYSICIANS.

THE SOUTHEASTERN COLLEGE OF OSTEOPATHIC MEDICINE HAS AHEC CENTERS IN THE EVERGLADES AND IN CENTRAL FLORIDA SERVING SOME OF THE MOST RURAL AND INNER-CITY POVERTY AREAS OF OUR NATION. IN ITS FIRST OPERATIONAL YEAR 1500 WEEKS OF STUDENT TRAINING IN MEDICINE, NURSING, ALLIED HEALTH AND SOCIAL WORK HAVE OCCURRED IN THIS UNDERSERVED REGION AND MINORITY RECRUITMENT ACTIVITIES ARE UNDERWAY.

MR. CHAIRMAN, THE NATIONAL AHEC PROGRAM HAS PROVEN TO HAVE BEEN A WISE INVESTMENT FOR THE FEDERAL GOVERNMENT. SINCE 1972, FEDERAL FUNDING FOR AHECS NATIONWIDE HAS TOTALED ABOUT THE SAME AMOUNT THAT THE U.S. OBLIGATES FOR THE HEALTH CARE FINANCING ADMINISTRATION EVERY TWO TO THREE DAYS. THAT MODEST AMOUNT OF FEDERAL SPENDING HAS LED TO THE ESTABLISHMENT OF AHECS FOR 32 STATES, 26 OF WHICH ARE STILL RECEIVING FEDERAL FUNDS. AND IT HAS SPURRED STATE AND LOCAL GOVERNMENTS INTO SPENDING HUNDREDS OF

MILLIONS OF DOLLARS FOR AHEC PROGRAMS IN RESPONSE TO THE FEDERAL CATALYST. THIS YEAR, FOR EXAMPLE, THE STATE OF NORTH CAROLINA HAS APPROPRIATED $28 MILLION FOR AHEC ACTIVITIES.

THE NATIONAL AHEC PROGRAM DEMONSTRATES OUR GOVERNMENT WORKING AT ITS BEST. WE INVITE THE SUBCOMMITTEE TO REVIEW THE STRONG ENDORSEMENTS OF THE AHEC PROGRAM CONTAINED IN THE FOLLOWING STUDIES:

1. THE 1978 REPORT OF THE GENERAL ACCOUNTING OFFICE;
2. THE 1978 REPORT OF THE HOUSE APPROPRIATIONS COMMITTEE;
3. THE 1976 AND 1979 REPORTS OF THE CARNEGIE COUNCIL;
4. THE 1980 REPORT TO THE CONGRESS BY THE SECRETARY OF H.E.W. AND
5. THE 1980 GMENAC REPORT.

WE IN AHEC HOPE THAT IN THE FISCAL YEAR 1989 BUDGET THE CONGRESS WILL MAINTAIN ITS COMMITMENT TO A PROGRAM AIMED AT ENDING THE MALDISTRIBUTION OF PHYSICIANS AND HEALTH PRACTITIONERS IN RURAL AND INNER-CITY AREAS. THIS COMMITMENT ALLOWS FOR FUNDING OF STATEWIDE AHEC'S, REGIONAL AHEC'S, AHEC SPECIAL INITIATIVES, INFANT MORTALITY, AND HIGH IMPACT AREAS. THE UNITED STATES, MR. CHAIRMAN, CANNOT AFFORD TO BE WITHOUT THIS PROGRAM.

THANK YOU AGAIN FOR THE OPPORTUNITY TO APPEAR HERE TODAY. WE IN THE AHEC PROGRAM LOOK FORWARD TO CONTINUING TO WORK WITH THE CONGRESS IN THE INTEREST OF ENSURING ACCESS TO PROPER HEALTH CARE FOR ALL AMERICANS.

Senator CHILES. We thank you, each of you, for your appearance here.

It does sound as if you are having some success. Certainly we know that it is very important that we have adequate, decent medical service in our rural areas.

I note the administration wants to combine a number of programs into a block grant. It doesn't seem like the money is exactly going to fit into a block grant that they are talking about.

I would note, again, that you have requested a considerable increase from $17.2 million to $26 million. I just want to point out to you that the committee finds itself, with this allocation of funds considerably less than the budget resolution provided, and it is going to be very, very tough to match all of our demands with our existing funds.

We think you have an important program and will certainly try to consider it.

Dr. MAYER. We understand that. We also would hope that the Congress would not block grant this and other programs in title VII.

Thank you.

Senator CHILES. Thank you.

STATEMENT OF MARJORIE A. BOWMAN, M.D., M.P.A., THE SOCIETY OF TEACHERS OF FAMILY MEDICINE

Senator CHILES. Now we will hear from Dr. Marjorie A. Bowman of the Society of Teachers of Family Medicine.

Dr. Bowman.

Dr. BOWMAN. Thank you.

I represent the Society of Teachers of Family Medicine, which is an organization of 2,500 educators who participate in the training of medical students and residents with the goal of teaching them all about family practice.

Family practice is a specialty which emphasizes continuous and comprehensive care for individuals and families in the context of their environment, their work, and their community.

Family medicine emphasizes humanism, preventive medicine and behavioral sciences, and sees many of our elderly patients.

Family medicine is in short supply. A few years ago, the GMENAC Committee recommended that there be continued Federal support of family medicine training programs, and, if there were sufficient support, that there might be enough family physicians in 1990.

More recently, the Council on Graduate Medical Education has concluded that there continues to be an undersupply of family physicians, that Federal grant programs for primary care should be continued, and that there need to be revisions in Medicare and Medicaid reimbursement policies to encourage training in the primary care specialties.

There are several economic issues in family medicine which are part of the reason for needing the training support.

The Federal funds under section 780 and section 786 have been a vital part of where family medicine has received funding for its training programs. It has been estimated that over 90 percent of graduates of family medicine residency training programs have been in programs that have received some amount of Federal funding from these sources.

Family medicine is primarily an outpatient and cognitive specialty. As we know, and is being reemphasized by the Physician Payment Review Commission, nonprocedural thinking types of care and outpatient services tend to be less well reimbursed. This has been magnified for Medicare patients because of fee freezes and determinations of maximum allowable charges.

We do hope that the Physician Payment Review Commission's report will be helpful in elucidating and arriving at ways to help with this problem of physician reimbursement.

In addition, much of the training for family medicine occurs in outpatient settings. This is inherently more inefficient. In a hospital setting, where a patient is available 24 hours a day, a trainee can see a patient without interfering with the overall efficiency of care. However, on the ambulatory facility, many patients are seen each day and each patient is available only for a limited period of time. When a student sees a patient, an examining room is occupied, therefore, reducing its availability for others.

Overall, this means that ambulatory training is inefficient.

On the other hand, it is a must for training good, cost-effective practitioners.

Thus, for several reasons, including lower reimbursement for outpatient and cognitive activities, geographic and specialty differentials in pay for same service, and inefficiencies inherent in teaching in ambulatory care settings, family medicine education has been difficult to fund from the traditional source of patient care dollars.

PREPARED STATEMENT

We appreciate the support that this committee has given us in the past and feel that ongoing Federal support for funding of family medicine education is a must and should actually be increased.

We welcome and hope for your continued support.

[The statement follows:]

STATEMENT OF MARJORIE A. BOWMAN

The Society of Teachers of Family Medicine would like to thank the committee for the opportunity to present this testimony in support of appropriations for sections 780 and 786 of the Public Health Service Act, the aspect of the appropriations that are of most immediate concern to us.

The Society of Teachers of Family Medicine represents more than 2500 educators (including family physicians, other medical specialists, and behavioral scientists) who are involved in teaching family practice to medical students and residents.

Family Practice is a medical specialty which emphasizes continuous and comprehensive care for individuals and families in the context of their immediate environment, their work, and their community. Family physicians emphasize humanism, preventive medicine and behavioral sciences, and particularly work to help people help themselves. Family physicians are cost-effective providers, emphasizing quality ambulatory medical care, avoiding hospitalization when possible, and using laboratory and diagnostic studies judiciously. Their ongoing contact with the individual and family allows for appropriate consideration of the full medical and social history while caring for the patient. Family physicians see a substantial percentage of elderly patients.

Family medicine is a relatively new specialty, beginning in 1969 with the establishment of the American Board of Family Practice. Most major studies over the years have noted an insufficient number of family physicians. The conclusion by the Graduate Medical Education National Advisory Committee (GMENAC) that there would be a sufficient supply of family physicians rested on the assumption of a steady trend in the number of residents in training, an assumption that could be untrue if Federal dollars are decreased. GMENAC thus recommended that there be continued Federal support of family medicine residency training programs.

More recently, the Council on Graduate Medical Education has concluded that: 1) there is an undersupply of family physicians; 2) Federal grant programs for primary care should be continued; and 3) there should be revisions in Medicare and Medicaid reimbursement policies to encourage training in primary care specialties.

Many family medicine graduates practice in areas of need. As compared to other specialties they are more likely to locate in more rural areas; about half of the graduates of family medicine residency programs practice in towns or areas of 25,000 people or less. Family medicine graduates also stay in family medicine; very few enter other specialty training after their residencies.

Family practice residency education has more training in an ambulatory setting than do other specialties. At least one quarter of the training time is in a Family Practice Center; at least an additional one quarter of the residents' time is spent in other ambulatory settings. Medical students who have family practice experiences spend most of that time in family practice offices.

The supply of family physicians has not kept up with the demand. As noted in testimony before the Council on Graduate Medical Education, the demand for family physicians is high. The supply is much more tenuous. One-third of the family physicians are over age 55. Also, the interest in primary care residencies appears to have declined, as least on the basis of the results of the resident matching program for this year. Economics are cited as one of the reasons for less interest in primary care practice. A decline in the number of physicians training in family practice and primary care is the opposite of what we need for the health care needs of the country.

There are several economic issues in family practice and the training of family physicians. The education for family medicine has been funded in multiple ways. Hospitals have contributed much support. Some state governments have provided a level of support. Teaching programs also provide care to patients and some money derives from this source. Medical schools have contributed a small amount of support. In addition, the Federal government has provided support through federal training grants under Sections 780 and 786.

These Federal funds have been crucial to the development of family medicine. It has been estimated that over 90% of graduates of family practice residency training programs have been in programs that received some amount of Federal funding. Federal funding has helped programs to increase resident enrollment, thus providing more graudates for the practice of family medicine.

One question that frequently arises is, "Why should family medicine need Federal dollars for the support of its training programs?" While there are several reasons, most of the reasons revolve around patient care reimbursement and the design of family medicine education.

Family medicine is primarily an outpatient and cognitive specialty. This means that family physicians spend most of their time in the office seeing patients, rather than in the hospital or specifically doing procedures. It has been recognized that outpatient activities and those involving non-procedural, thinking types of care are less well reimbursed. Per hour the physician gets less pay. For Medicare patients, this has been magnified by the fee freeze and determinations of maximum allowable charges. An editorial in the New England Journal of Medicine highlights these issues for general internists. The general internist writes that his income has dropped for each of the last several years and that other physicians in the area are leaving because of inadequate income. Legislation passed in 1987 does provide some improvements for primary care, but the amount of change would appear to be insufficient to resolve the major discrepancies that have developed.

Family physicians have even more problems than do general internists. Family and general practitioners are separated from other specialists in determining potential fees. Other specialists may be paid several times as much for the same service as is a family physician. In my immediate area of the country, several family physicians have told me that they are not taking new Medicare patients because the rates of reimbursement are too low to adequately cover office overhead, let alone pay the physician for the time spent. Family practice continues to be one of the lowest paid specialties. The Physician Payment Review Commission has been reviewing, in general, the issue of physician reimbursement.

Medical education has been heavily funded by patient care dollars. Whether or not this is fully appropriate will not be debated here. Because of the problems in reimbursement in family medicine and outpatient medicine, it is difficult to readily fund family medicine training from patient care dollars. In addition to lower collections relative to hospital based procedure-oriented specialties, education in primary care outpatient facility is more expensive, with trainees generally decreasing the efficiency of the office practice. In the hospital, patients are there 24 hours a day, thus a student can see them at different times and spend time with them without actually slowing down the process of care. In an ambulatory facility, many more patients are seen per day, and each patient is available for only a limited period of time. When a student sees a patient, an examining room is occupied for some amount of time that would otherwise be used by the attending pysician. This activity further decreases office efficency. Ambulatory experience is a must for training physicians in ambulatory, cost-effective medicine.

Thus family medicine education has been more difficult to fund from patient care dollars because of 1) lower reimbursement for outpatient and cognitive activities, 2) geographic and specialty differentials in pay for the same service, and 3) inefficiences inherent in teaching in ambulatory care settings.

Other than patient care dollars, there is limited funding available for family medicine education.

For these reasons and for the other concerns outlined in this presentation, it is vital that Federal support for funding of family medicine education be increased. We welcome and hope for your continued support of family medicine education.

Senator CHILES. We thank you for your appearance and want you to understand that the subcommittee feels family medicine is very important. We have been trying to provide an emphasis on that in our funding in the past, and, within our constraints, again, we will see what we can do.

This is another one of the programs that the administration has suggested we fold into the block grant.

Dr. BOWMAN. We do not think the block grant will work.

Senator CHILES. Well, the consolidated block grant request is going to be $40 million, and I would note that we have funded family medicine departments at $42.1 million last year.

Dr. BOWMAN. Yes.

Senator CHILES. So we are going to have a hard time fitting all of that in.

But we thank you for your appearance here today.

Dr. BOWMAN. Thank you very much.

STATEMENT OF BILL FINERFROCK, DIRECTOR OF FEDERAL AFFAIRS, AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

Senator CHILES. Now we will hear from Bill Finerfrock, the director of Federal affairs of the American Academy of Physician Assistants.

Mr. FINERFROCK. Thank you, Mr. Chairman.

On behalf of the American Academy of Physician Assistants I want to thank you for opportunity to present our views on the fiscal year 1989 Labor-HHS appropriations bill.

Our comments will focus on appropriations for health professions education, in particular, physician assistant education.

Health professions educational assistance programs under title VII of the Public Health Service Act have made it possible for many deserving young men and women to obtain a health professions education who might otherwise have been denied such an opportunity.

More specifically, section 783, grants to physician assistant programs, has not only helped the PA profession grow and expand, but has also helped programs develop and maintain an educational experience that insures that graduates select careers in those practice settings and specialties of greatest national need.

Therefore, the academy strongly encourages the full funding at the $4.8 million level of the highly successful PA educational grants program.

The academy is concerned that, should these grants be discontinued or reduced, as has been proposed by the administration, many well-qualified individuals will be locked out of the health professions. In addition, the lack of Federal assistance will have a dramatic impact on the job choices future health professionals will make.

As your subcommittee assesses the impact of PA program grants, we hope you will keep several points in mind.

First, there is presently a severe shortage of physician assistants throughout the country.

Second, physician assistants have exhibited a willingness to work in those urban and rural communities designated as medically underserved.

Third, the overwhelming majority of physician assistants are in the primary care/family practice areas.

Fourth, more than 20 percent of all PA students are minorities.

Fifth, 30 percent of all PA's practice in rural communities.

According to the Office of Technology Assessment, in a December 1986 report to Congress, "PA's have also contributed notably to improved geographic access to care."

A significant percentage of physician assistants are working in rural and urban medically underserved communities. Whereas 27 percent of the general population and 14 percent of physicians are located in rural areas, more than 30 percent of all PA's are located in these communities.

Furthermore, 11 PA programs have specific initiatives which benefit inner city medically underserved populations. Right here in the District of Columbia, for instance, Howard University puts all of its PA students through a clinical rotation, providing health care to homeless individuals in the District.

Other PA programs offer clinical rotations at chemical dependency programs, adolescent pregnancy clinics, and sexually transmitted disease clinics.

More recently, programs have expanded to include extensive AIDS education as part of the basic curriculum.

Under the present PA program grant criteria, grant moneys are used to train PA's for the delivery of primary care in ambulatory care settings, place graduates in medically underserved areas, and recruit residents of medically underserved areas, minority groups, and women to enter the PA profession.

These criteria are a major factor in why PA's are still being found in rural and urban medically underserved primary care settings.

Mr. Chairman, PA program grants have also been a successful mechanism for recruiting minorities into the PA profession. We have seen a steady rise in the number of minorities attending PA programs culminating in 1987, with over 20 percent of PA students being classified as minorities. This figure compares favorably with the numbers evidenced in 1983, when minorities represented 13.8 percent of all PA students.

Continued funding of PA program grants is particularly important at this time in history. Those practice settings and specialties traditionally served by PA's are finding it increasingly difficult to attract and retain qualified physician assistants. The increased demand has been particularly acute within the public health community. The Bureau of Prisons and the Indian Health Service have both reported a significant shortage of PA's.

As the subcommittee proceeds with its deliberations on the funding levels of health professions educational assistance under title VII, we trust you will keep this in mind. Failure to appropriately fund program grants would have a significant implication on the profession; but, more importantly, it would have a profound impact on the ability of millions of individuals to have access to quality health care.

PREPARED STATEMENT

Your past support has been appreciated. The academy looks forward to working with you and your staff.

[The statement follows:]

STATEMENT OF BILL FINERFROCK

MR. CHAIRMAN, ON BEHALF OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS, I WANT TO THANK YOU FOR THIS OPPORTUNITY TO PRESENT OUR VIEWS ON THE FY 1989 LABOR-HHS APPROPRIATIONS BILL. OUR COMMENTS WILL FOCUS ON APPROPRIATIONS FOR HEALTH PROFESSIONS EDUCATION, IN PARTICULAR, PHYSICIAN ASSISTANT EDUCATION.

HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE PROGRAMS UNDER TITLE VII OF THE PUBLIC HEALTH SERVICE ACT HAVE MADE IT POSSIBLE FOR MANY DESERVING YOUNG MEN AND WOMEN TO OBTAIN A HEALTH PROFESSIONS EDUCATION WHO MIGHT OTHERWISE HAVE BEEN DENIED SUCH AN OPPORTUNITY.

MORE SPECIFICALLY, SECTION 783, GRANTS TO PHYSICIAN ASSISTANT PROGRAMS, HAS NOT ONLY HELPED THE PA PROFESSION GROW AND EXPAND BUT HAS ALSO HELPED PROGRAMS DEVELOP AND MAINTAIN AN EDUCATIONAL EXPERIENCE THAT INSURES THAT GRADUATES SELECT CAREERS IN THOSE PRACTICE SETTINGS AND SPECIALTIES OF GREATEST NATIONAL NEED.

THEREFORE, THE ACADEMY STRONGLY ENCOURAGES THE FULL FUNDING, AT THE $4.8 MILLION DOLLAR LEVEL, OF THE HIGHLY SUCCESSFUL PA EDUCATIONAL GRANTS PROGRAM.

THE ACADEMY IS CONCERNED THAT SHOULD THESE GRANTS BE DISCONTINUED OR REDUCED, AS HAS BEEN PROPOSED BY THE ADMINISTRATION, MANY WELL-QUALIFIED INDIVIDUALS WILL BE "LOCKED-OUT" OF THE HEALTH PROFESSIONS. IN ADDITION, THE LACK OF FEDERAL ASSISTANCE WILL HAVE A DRAMATIC IMPACT ON THE JOB CHOICES FUTURE HEALTH PROFESSIONALS WILL MAKE.

AS YOUR SUBCOMMITTEE ASSESSES THE IMPACT OF PA PROGRAM GRANTS, WE HOPE YOU WILL KEEP SEVERAL POINTS IN MIND:

1. THERE IS PRESENTLY A SEVERE SHORTAGE OF PHYSICIAN ASSISTANTS THROUGHOUT THE COUNTRY.

2. PHYSICIAN ASSISTANTS HAVE EXHIBITED A WILLINGNESS TO WORK IN THOSE URBAN AND RURAL COMMUNITIES DESIGNATED AS MEDICALLY UNDERSERVED.

3. THE OVERWHELMING MAJORITY OF PHYSICIAN ASSISTANTS ARE IN THE PRIMARY CARE/FAMILY MEDICINE AREAS.

4. MORE THAN 20 PERCENT OF ALL PA STUDENTS ARE MINORITIES.

5. 30 PERCENT OF ALL PAs PRACTICE IN RURAL COMMUNITIES.

SHORTAGE OF PAs

ACCORDING TO SURVEY DATA, THE AVERAGE JOBS/GRADUATE RATIO IS 7.5 JOBS PER GRADUATE FOR PHYSICIAN ASSISTANT STUDENTS. THIS IS CONSISTENT WITH THE FINDINGS OF THE DEPARTMENT OF LABOR'S BUREAU OF LABOR STATISTICS WHICH RECENTLY REPORTED:

> "EMPLOYMENT OF PAs IS EXPECTED TO GROW MUCH FASTER THAN THE AVERAGE FOR ALL OCCUPATIONS THROUGH THE YEAR 2000 DUE TO ANTICIPATED EXPANSION OF THE HEALTH SERVICE INDUSTRY AND GREATER RELIANCE ON PA'S TO PROVIDE PRIMARY CARE AND ASSIST WITH COMPLEX MEDICAL AND SURGICAL PROCEDURES. PROSPECTS FOR NEWLY TRAINED PAs ARE EXCELLENT SINCE DEMAND IS EXPECTED TO OUTSTRIP SUPPLY."

IN ADDITION, *U.S. NEWS AND WORLD REPORT* RECENTLY LISTED THE PA PROFESSION AS ONE OF THE FASTEST GROWING PROFESSIONS IN THE UNITED STATES.

RURAL/URBAN MEDICALLY UNDERSERVED AREAS (MUAs):

ACCORDING TO THE OFFICE OF TECHNOLOGY ASSESSMENT (OTA), IN A DECEMBER, 1986 REPORT TO CONGRESS, "PAs HAVE ALSO CONTRIBUTED NOTABLY TO IMPROVED GEOGRAPHIC ACCESS TO CARE." A SIGNIFICANT PERCENTAGE OF PHYSICIAN ASSISTANTS ARE WORKING IN RURAL AND URBAN MEDICALLY UNDERSERVED COMMUNITIES. WHEREAS 27 PERCENT OF THE GENERAL POPULATION AND 14 PERCENT OF PHYSICIANS ARE LOCATED IN RURAL AREAS (DEFINED AS NON-SMSA), MORE THAN 30 PERCENT OF ALL PAs ARE LOCATED IN THESE COMMUNITIES.

IN ADDITION TO CHOOSING PRACTICES SERVING DISADVANTAGED POPULATIONS, PAs HAVE ALSO SHOWN GREAT CONSISTENCY IN OPTING

FOR PRIMARY CARE SPECIALTIES. ACCORDING TO OUR OWN MASTERFILE SURVEY, 65 PERCENT OF ALL PHYSICIAN ASSISTANTS WORK IN A PRIMARY CARE SPECIALTY (INTERNAL MEDICINE, OB/GYN, PEDIATRICS, FAMILY MEDICINE, ETC.).

FURTHERMORE, 11 PA PROGRAMS HAVE SPECIFIC INITIATIVES WHICH BENEFIT INNER-CITY MEDICALLY UNDERSERVED POPULATIONS. RIGHT HERE IN THE DISTRICT OF COLUMBIA, FOR INSTANCE, HOWARD UNIVERSITY PUTS ALL OF ITS PA STUDENTS THROUGH A CLINICAL ROTATION PROVIDING HEALTH CARE TO HOMELESS INDIVIDUALS IN THE DISTRICT. OTHER PA PROGRAMS OFFER CLINICAL ROTATIONS AT CHEMICAL DEPENDENCY PROGRAMS, ADOLESCENT PREGNANCY CLINICS AND SEXUALLY TRANSMITTED DISEASE CLINICS. MORE RECENTLY, PROGRAMS HAVE EXPANDED TO INCLUDE EXTENSIVE AIDS EDUCATION AS PART OF THE BASIC CURRICULUM.

UNDER THE PRESENT PA PROGRAM GRANT CRITERIA, GRANT MONIES ARE USED TO TRAIN PAs FOR THE DELIVERY OF PRIMARY CARE IN AMBULATORY CARE SETTINGS, PLACE GRADUATES IN MEDICALLY UNDERSERVED AREAS, AND RECRUIT RESIDENTS OF MEDICALLY UNDERSERVED AREAS, MINORITY GROUPS AND WOMEN TO ENTER THE PA PROFESSION. THESE CRITERIA ARE A MAJOR FACTOR IN WHY PAs ARE STILL BEING FOUND IN RURAL AND URBAN MEDICALLY UNDERSERVED PRIMARY CARE SETTINGS.

MINORITY RECRUITMENT:

MR. CHAIRMAN, PA PROGRAM GRANTS HAVE ALSO BEEN A SUCCESSFUL MECHANISM FOR RECRUITING MINORITIES INTO THE PA PROFESSION. WE HAVE SEEN A STEADY RISE IN THE NUMBER OF MINORITIES ATTENDING PA PROGRAMS CULMINATING IN 1986/87 WITH OVER 20 PERCENT OF PA STUDENTS BEING CLASSIFIED AS MINORITIES. THIS FIGURE COMPARES FAVORABLY WITH THE NUMBERS EVIDENCED IN 1983 WHEN MINORITIES REPRESENTED 13.8 PERCENT OF ALL PA STUDENTS. AGAIN, WE BELIEVE THE PA PROGRAM GRANTS HAVE BEEN A MAJOR REASON FOR THIS RATHER DRAMATIC RISE IN MINORITY ENROLLMENT.

IMPACT OF DISCONTINUATION:

SHOULD PA PROGRAM GRANTS BE DISCONTINUED OR REDUCED, OR REPLACED WITH THE BLOCK GRANT APPROACH RECOMMENDED BY THE ADMINISTRATION, WE FEAR THAT MANY OF THE GAINS EVIDENCED OVER THE PAST SEVERAL YEARS WILL BE NEGATED.

CONCLUSION:

CONTINUED FUNDING OF PA PROGRAM GRANTS IS PARTICULARLY IMPORTANT AT THIS TIME IN HISTORY. THOSE PRACTICE SETTINGS AND SPECIALTIES TRADITIONALLY SERVED BY PAs ARE FINDING IT INCREASINGLY DIFFICULT TO ATTRACT AND RETAIN QUALIFIED PHYSICIAN ASSISTANTS. THE INCREASED DEMAND HAS BEEN PARTICULARLY ACUTE WITHIN THE PUBLIC HEALTH COMMUNITY. THE BUREAU OF PRISONS AND INDIAN HEALTH SERVICE HAVE BOTH REPORTED A SIGNIFICANT SHORTAGE OF PAs.

IN LIGHT OF THE WIDESPREAD RECOGNITION THAT THE DEMAND FOR HEALTH CARE (PARTICULARLY PRIMARY CARE) WILL INCREASE AS OUR POPULATION AGES, NOW IS NOT THE TIME TO REDUCE OR ELIMINATE THE VERY PROGRAM THAT HAS BEEN SO SUCCESSFUL AT PRODUCING PRIMARY CARE PROVIDERS.

PA PROGRAMS HAVE SHOWN A WILLINGNESS TO STRUCTURE THE PA EDUCATIONAL EXPERIENCE TO THE NEEDS OF THE COMMUNITY. CONSEQUENTLY, TREMENDOUS EFFORTS HAVE BEEN MADE TO IMPROVE THE GERIATRIC COMPONENT OF PA PROGRAMS, EXPAND HOME HEALTH CARE ROTATIONS AND PLACE INCREASED EMPHASIS ON HEALTH PROMOTION AND DISEASE PREVENTION AS PART OF THE CORE CURRICULUM.

AS THE SUBCOMMITTEE PROCEEDS WITH ITS DELIBERATIONS ON THE FUNDING LEVELS OF HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE UNDER TITLE VII, WE TRUST YOU WILL KEEP THIS IN MIND. FAILURE TO APPROPRIATELY FUND PROGRAM GRANTS WOULD HAVE SIGNIFICANT IMPLICATIONS ON THE PA PROFESSION, BUT MORE IMPORTANTLY, IT WOULD HAVE A PROFOUND IMPACT ON THE ABILITY OF MILLIONS OF INDIVIDUALS TO HAVE ACCESS TO QUALITY HEALTH CARE.

YOUR PAST SUPPORT HAS BEEN MOST APPRECIATED, MR. CHAIRMAN. THE ACADEMY LOOKS FORWARD TO WORKING WITH YOU AND YOUR STAFF IN THE COMING MONTHS.

Senator CHILES. We thank you and we will certainly try to consider that.

Now we will hear from Mr. Ricardo Valdez, assistant dean of the University of California at Irvine.

[No response.]

Senator CHILES. He may not be here now.

STATEMENT OF ROBERT T. CROTHERS, PRESIDENT, BOARD OF DIRECTORS, NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, INC.

Senator CHILES. We will try next Mr. Robert T. Crothers, president, Board of Directors of the National Family Planning and Reproductive Health Association.

Mr. Crothers.

Mr. CROTHERS. Mr. Chairman, I am Robert Crothers, the president of the National Family Planning and Reproductive Health Association, sometimes known as NFPRHA.

I want to thank you and the subcommittee for the opportunity to address the issue of continued funding for title X of the Public Health Service Act, population research and voluntary family planning programs.

We have previously submitted written testimony and would ask that it be incorporated in the record of this hearing.

NFPRHA is a nonprofit membership organization, representing the entire family planning community. It includes 73 of 86 title X grantees, as well as other health care providers and consumers of reproductive health care services clients.

NFPRHA is committed to establishing and maintaining voluntary family planning and reproductive health care as a high priority preventative health care service for the poor, medically indigent, or underserved.

Title X is the primary source of funding for the preventative health care service.

Since its inception in 1970, the National Family Planning Program has enjoyed broad support in Congress and in this committee. I urge you to continue that long-standing commitment to the poor and medically indigent by appropriating $163 million for direct services and an additional $20 million for contraceptive research and community-based information and education under title X in fiscal year 1989, as described in my written testimony.

We oppose the administration's budget proposal of $140 million as woefully inadequate.

Title X is a medical program that serves a target population most in need of medical care. These title X funded clinics are the entry point for millions of low-income women and adolescents into the Nation's health care system. These patients are typically not going to seek preventative reproductive health care at any other entry point, other than a title X funded clinic.

They will simply go without.

Typical title X programs offer clinical health services, including physical examinations, contraceptive information and services, sexually transmitted disease screening and treatment, cancer screening, and other basic gynecological care.

They also provide counselling for nutrition and infertility and adolescent health education and community health education.

Hundreds of thousands of unintended pregnancies are averted each year as a result of subsidized title X services. These Federal dollars more than pay for themselves in savings in other public health care and social service costs. But, more important, the program is providing health care to those who need it most but who can afford it least.

The need for continued support is clear. Since the early 1970's, the number of medical indigent family planning clients has grown by 60 percent; yet, Federal funding has not increased in real dollars since 1973.

Title X's appropriations have gone from $162 million in fiscal year 1981 to $142.5 million in fiscal year 1988. Inflationary increases alone should have brought the current funding level to $237 million by this year.

We are asking only to restore some of the economic tightening that has occurred in the past 7 years to the $163 million mark.

The clients have suffered with these funding limitations by reduced clinic operating hours and other belt-tightening measures, and unmet need for services continues to exist.

The irony is that by limiting the title X program with funding cuts, the result is far greater social and financial costs to other federally funded social service programs and for a significantly longer period of time.

The prevention of unintended pregnancy limits the necessity for future social and economic services to those families and children.

The early detection and treatment of reproductive health problems limits future catastrophic health care costs, especially to these traditional uninsured and underinsured populations.

As your mother used to say, an ounce of prevention is worth a pound of cure.

I could spend a great deal of time describing for you the efforts of the administration to undermine the title X program and to substitute political and personal ideology for statutory requirements of title X. My written testimony does that.

No matter what ideology you may have, the successes of the title X Family Planning Program cannot be ignored. They speak forcefully for this subcommittee and Congress to continue appropriations for title X of $163 million for fiscal year 1989.

PREPARED STATEMENT

I thank you very much for your consideration and would be happy to entertain any questions you may have.

[The statement follows:]

STATEMENT OF ROBERT T. CROTHERS

I am Robert T. Crothers, a partner in the law firm of Peacock, Keller, Yohe, Day and Ecker of Washington, Pennsylvania and the President of the National Family Planning and Reproductive Health Association, Inc. (NFPRHA). I want to thank you and this subcommittee for the opportunity to address the issue of continued funding for Title X of the Public Health Service Act, "Population Research and Voluntary Family Planning Programs."

The National Family Planning and Reproductive Health Association (NFPRHA) is a non-profit membership organization headquartered in Washington, D.C., established to improve and expand the delivery of voluntary family planning and reproductive health services throughout the United States. As the only national organization representing the entire family planning community, NFPRHA's members comprise almost all grantees funded under the national Title X family planning program. NFPRHA represents 73 of the 86 Title X grantees across the United States who, in fiscal year 1988, received nearly 90 percent of the Title X family planning service dollars. Among those NFPRHA represents are hospitals; state and local health departments; affiliates of the Planned Parenthood Federation of America; independent non-profit family planning agencies; individual doctors, nurses, and researchers; and consumers of reproductive health care services. NFPRHA is committed to establishing and maintaining reproductive health care as a high priority preventive health care service in this country.

Title X is the primary source of federal funding for subsidized voluntary family planning services in this country. Since its inception in 1970, the national family planning program under Title X has enjoyed broad bipartisan support in Congress, and in this committee. I urge you and your colleagues to sustain that long-standing committment to quality reproductive health care for all by appropriating $163 million for direct services and other programs under Title X in fiscal year 1989 versus the administration's fiscal year 1989 budget proposal of $140 million. It is important to note that only $136.3 million of the administration's request would go to Title X grantees while $3.7 million would support the administrative expenses of the Office of Population Affairs (OPA) and the Department of Health and Human Services (DHHS) regional family planning offices.

Title X is a medical program serving poor Americans, but it also authorizes contraceptive research and development, and research in the reproductive and behavioral sciences. The development of improved methods of contraception would help reduce the number of unintended pregnancies in this country, which accounted for over 50 percent of all pregnancies last year. Less than ten percent of the current budget of the Center For Population Research of the National Institute of Child Health and Human Development (NICHD) goes for contraceptive development. For that reason, NFPRHA requests that Congress fund NICHD population research activities at least at the administration's requested level of $129.782 million. In addition, NFPRHA requests that Congress grant a special additional appropriation of $10 million each year for the next four years to focus specifically on improving contraceptive technology.

In this year of budgetary austerity, an adequate federal investment in family planning is more valuable than ever before.

Title X is a medical program that serves the poor and the medically indigent. Title X clinics are the entry point for millions of low-income women and adolescents into the nation's health care system.

Hundreds of thousands of unintended pregnancies, many among teenagers, are averted each year as a direct result of services provided by clinics receiving Title X funds. The federal dollars invested in Title X more than pay for themselves in savings in public health care and social service costs in the next year alone.

Typical Title X programs offer clinical health services (physical examinations, contraceptive information and services, Pap smears, sexually transmitted disease screening and treatment, cancer screening, hemoglobin tests, urinalysis, pregnancy testing and diagnosis, and basic gynecologic care); counseling services (for nutrition, infertility, parent/teen communication, maternal and child health, problem pregnancies, and related medical problems); services for men (counseling, education, condoms); special teen clinics; adolescent health education; and community education programs.

The need for continued adequate support for Title X is clear and considerable. Even with Title X, many of the 9.5 million low-income women and five million sexually-active teenagers in need of subsidized family planning services still cannot obtain medically supervised reproductive health care.

Federal, state, and local financial support for family planning has never reached a level commensurate with need. Since the early 1970's, the number of medically indigent family planning clients has grown more than 60 percent, yet federal funding for family planning has not increased in real dollars since 1973.

In the last seven years, Title X's appropriation has gone from $162 million in FY 1981 to $142.5 million in FY 1988. Inflationary increases alone should have brought the current level of Title X funding to $237 million by this year. The clinics have stayed open, but the belt-tightening shows. Operating hours have been reduced, staff have been cut, and indigent patients have been asked to contribute more to the cost of services. The irony of this is, of course, that diminishing a program as effective and cost-efficient as Title X results only in far greater social and financial costs down the line.

While struggling with draconian budget cuts, Title X providers have also had to contend with inappropriate management and improper harassment from the DHHS' OPA, the federal office charged with administering the national family planning program. Through a series of inapt efforts to substitute political ideology for statutory requirements, the resources of DHHS have been misapplied to undermine the delivery of high quality family planning services to millions of low-income women and adolescents.

I raise these concerns about the management of the federal family planning program before you today because NFPRHA understands that, as the officials responsible for appropriating millions of dollars in federal monies, you have a fundamental interest in seeing that those funds are put to work in an efficient and appropriate manner.

Last year, it appeared that the personal anti-abortion philosophy of the former Deputy Assistant Secretary for Population Affairs (DASPA), Mrs. Jo Ann Gasper, and her senior advisors distorted the administration of the Title X program -- a program designed to prevent the incidence of abortion through preventive family planning services. In media interviews, and personal appearances, Mrs. Gasper had implied that her personal loyalties and convictions led her to implement the Title X program in a way that was in contradiction to seventeen years of DHHS' policy, in contradiction to DHHS General Counsel advice, and even in contradiction to the Title X statutory history and Congressional intent. This, in the end, resulted in her dismissal.

Unfortunately, through its new DASPA, N. Nabers Cabaniss, DHHS has not disavowed the actions of the former DASPA nor indicated that the family planning program will now be administered in a professional and competent manner. Ms. Cabaniss is the third DASPA in a row who is opposed to the Title X program. In prior positions, Ms. Cabaniss supported and undertook efforts to undermine the Title X program.

Most recently, Ms. Cabaniss and DHHS promulgated "The Gag Rule," regulations which would prevent pregnant poor women from receiving complete, accurate and high quality information and medical care from Title X family planning clinics that provide any abortion-related information or counseling. The Gag Rule has been enjoined in federal court in a lawsuit brought by NFPRHA. The court found the Gag Rule illegally contravenes the intent of Congress in establishing the Title X program, violates medical ethics and practice standards, and unconstitutionally interferes with the First Amendment and privacy rights of women and their physicans to discuss legal medical options of care.

Numerous DHHS Office of the Inspector General (OIG), U.S. General Accounting Office (GAO), Congressional and other investigations and audit reviews have demonstrated strict compliance by Title X grant fund recipients with the terms, conditions and intent of the Title X statute, its regulations and guidelines regarding Section 1008 of the law (denying the use of Title X funds in programs where abortion is a method of family planning.) Nonetheless, OPA has consistently attempted to force the denial of Title X funds to agencies that provide abortions with non-federal funds, or even provide non-directional counseling and referral for pregnancy termination in compliance with Title X's own rules. Nabers Cabaniss' personal biases have led her to attempt to administer the Title X program in contradiction to fact and law. Despite an inability to cite any examples of violations of Section 1008 when asked to do so, Ms. Cabaniss and her deputies have continued to place unwarranted emphasis on Section 1008 compliance to the detriment of other program functions of the Office of Population Affairs.

The extraordinary efforts DHHS and OPA have undertaken to formulate the enjoined Gag Rule and other ideological attacks on the family planning program have precluded any competent effort to address the appropriate administrative and managerial concerns facing Title X projects today. The following is only a short list of the many items of crucial importance that are being ignored or improperly handled by the Office of Population Affairs:

- The formula for allocating Title X service dollars is woefully out-of date, yet the only effort to revise it was motivated by a philosophy designed to skew funding from cost-efficient preventive family planning services requested by clients to costly, seldom requested services. So poorly-prepared was the formula that members of this committee stepped in to block its implementation during Fiscal Year 1987 with report language in that year's Continuing Resolution. The proposed formula took over one year to prepare and was created without active input from the service providers most aware of its potential implications.
- The spread and treatment of sexually transmitted diseases such as chlamydia and penicillin resistant gonorrhea requires uniform advice from the Office of Population Affairs, yet OPA has not provided any direction to the projects it administers.
- The Office of Population Affairs has circumvented the law requiring the establishment of a National Adoption Clearinghouse and has utilized Title X funds and contracts to establish a "National Clearinghouse on Family Life Information." A clearinghouse to focus solely on the distribution of information and materials to family planning providers is required, and prior to FY 1987 such a clearinghouse was supported by Title X funds.
- The publication of notices of requests for Title X grant applications, and the awarding of grants and contracts, has occurred consistently late, creating major dislocations for the providers of family planning services and training programs.
- Requests for grant proposals have included or atttempts have been made to include, new and unique requirements designed to limit or deny grant awards to current training and service grantees of whom OPA disapproves, despite those grantees more-than-competently meeting the terms and conditions of their current grants.
- While refusing to address current management priorities despite repeated requests from grantees for advice and assistance in

those areas, the Office Population Affairs has repeatedly undertaken studies and issued directives with no apparent relationship to the direct competent provision of high quality family planning health care. These studies and directives merely foment confusion and concern in the family planning community. For example, OPA last year solicited information from around the country regarding state laws on child abuse and statutory rape; the only conceivable purpose for the collection of such information is for the preparation of a directive designed implicitly or explicitly to circumvent the Title X program's long-standing requirements for confidential services to adolescents.

- The Office of Population Affairs continues to push for the "de-funding" of agencies of which it disapproves for their involvement in abortion with non-federal funds, and just last week published a Request for Applications for nurse practitioner and general training grants that is intended to be utilized to "de-fund" current grantees.

Title X funds have never subsidized abortion procedures. Yet, under the guise of opposing abortion, some individuals and groups have sought to undermine the single most effective federal program for re-ucing the need for abortion -- Title X.

SUMMARY

Despite the attempts of the Reagan administration, the successes of the Title X family planning program cannot be ignored, and they speak forcefully for the reauthorization of Title X for four years and for NFPRHA's request that this subcommittee and Congress approve an appropriation for Title X of $163 million for Fiscal Year 1989, support contraceptive development with a special supplementary fund of $10 million and $10 million for expanded community-based information and ducation programs. Adequate funding of family planning and contraceptive research programs will send a strong message that Congress and this committee hold reproductive health care as a high priority, even in these times of fiscal constraint.

Thank you very much for your consideration of NFPRHA's requests. I would be happy to answer any questions you may have.

RECOMMENDATIONS OF THE NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION FOR FISCAL YEAR 1989 APPROPRIATIONS FOR THE TITLE X (PHS ACT) FAMILY PLANNING PROGRAM

1. Reject administration efforts to place federal support for family planning services into a block grant and reauthorize Title X for four years through passage of the Kennedy bill -- S. 1366.

2. Appropriate $163 million for programs under Title X; $4.515 million for training and technical assistance programs. These figures are equal to the fiscal year 1989 authorization levels levels provided under S. 1366 now pending consideration by the full Senate.

3. Ensure that funds appropriated for administrative expenses required for the administration of the Title X program by the Office of Population Affairs are appropriated in addition to the appropriation for family planning program activities, and that the exact amount of the appropriation for administrative expenses is clearly delineated in Congressional committee and conference reports.

4. Repudiate the inappropriate administration of the Title X family planning program by the Department of Health and Human Services' Office of Population Affairs, and resist all efforts to compromise the quality, confidentially, or scope of Title X services.

5. Appropriate funding for the Center for Population Research within the National Institute of Child Health and Human Development at least at the President's fiscal year 1989 request of $129.782 million to promote the development, marketing, and evaluation of new contraceptive devices, drugs, and methods.

6. Appropriate an additional $10 million for expanded community-based information and education programs, targeted especially for teenagers and parents, to help prevent and lower the incidence of unintended pregnancy and sexually-transmitted diseases as per the provision of S. 1366.

7. Appropriate an additional $10 million for the specific development and evaluation of new or improved contraceptives as per the provision of S. 1366.

Senator **Chiles**. We thank you for your testimony. Family planning is something that is vitally important. I wish we could do it a little bit better than we are doing it now.

Mr. **Crothers**. Thank you, sir.

STATEMENT OF JOHN FRIEL, EXECUTIVE DIRECTOR, THE COALITION FOR HEALTH FUNDING

Senator **Chiles**. Now we will hear from John Friel, executive director, the Coalition for Health Funding.

Mr. **Friel**. Good morning, Mr. Chairman. I am very happy to be here with you this morning to present the recommendations of the Coalition for Health Funding for the fiscal year 1989 appropriations for health programs.

Mr. Chairman, I would like to summarize my testimony and ask that the entire statement be made a part of the record.

Senator **Chiles**. It will be.

Mr. **Friel**. The Coalition for Health Funding is composed of some 40 national health organizations, representing over 10 million people in voluntary health agencies, consumers and providers of health services, and the institutions that train health professionals and others.

The thread that unites these diverse groups is an overriding concern and support for the research, service, and training programs at the U.S. Public Health Service. The primary objective of the coalition is to emphasize and protect the many and varied programs, projects, and activities of the Public Health Service that are of crucial importance to a strong and vital health care system in the United States.

Mr. Chairman, I appear before you today to discuss the coalition's serious concerns about the administration's budget request for the Public Health Service for fiscal year 1989.

Preliminarily, I would like to express the gratitude of our group for the support that the members of this subcommittee and staff have shown for the Public Health Services programs.

These programs, which range in mission and character from biomedical and behavioral research to assistance for students in all areas of health professions education, are the backbone of our system of health promotion and disease prevention and treatment.

In past years, this subcommittee has seen fit to approve significantly higher levels of funding for the Public Health Service than the administration has requested. We hope that you will do so again.

We recognize that in years past, there is more demand than there are resources. However, we believe that there can be no more deserving cause than protection of the health of our Nation by building upon the enormous strides being made in the areas of biomedical research and training.

These vital programs will suffer, however, if we do not act now to increase the level of discretionary health spending to an acceptable level.

The President has requested $12.75 billion in spending for discretionary health programs. This amount will simply maintain the fiscal year 1988 appropriated levels of spending for these programs. Maintenance of programs is unacceptable. We must move forward.

The coalition, therefore, requests a $2 billion increase over the President's budget request for discretionary health programs. Without these additional funds, the coalition fears that the Nation's health system will be seriously jeopardized.

The coalition applauds the President's increased awareness and commitment to the AIDS epidemic. We, as a Nation, must do everything we can to combat the AIDS crisis.

Efforts are underway throughout the Public Health Service to do so. The National Institutes of Health is vigorously pursuing treatments and a cure for this disease. The Alcohol, Drug Abuse, and Mental Health Administration is studying the behavioral aspects of the disease. The Centers for Disease Control has been the source of epidemiological data by which the spread of AIDS has been tracked and monitored, and has been in the forefront of the Public Health Service's efforts to institute public health measures to halt the progress of AIDS among high-risk populations.

The Health Resources and Services Administration has also allocated some resources to train health professionals to understand and care for patients afflicted by AIDS.

This unprecedented response by a variety of Public Health Service agencies to the AIDS emergency could not have been possible if Congress had not maintained these programs at a level of funding that allowed them to remain fully responsive.

PREPARED STATEMENT

Again, Mr. Chairman, I appreciate very much the opportunity to be with you this morning. The Coalition for Health Funding looks forward to continuing our excellent working relationship with the members of this subcommittee and its staff.

Thank you.

[The statement follows:]

STATEMENT OF JOHN FRIEL

Mr. Chairman, and members of the Subcommittee, my name is John Friel. I am Executive Director of the Coalition for Health Funding.

The Coalition for Health Funding is composed of some 40 national health organizations representing over 10 million people in voluntary health agencies, consumers and providers of health services, and the institutions that train health professionals and others. Attached to my testimony is a list of the Coalition members. The thread that unites these diverse groups is an overriding concern and support for the research and service and training programs at the U.S. Public Health Service ("PHS"). The primary objective of the Coalition is to emphasize and protect the many and varied programs, projects, and activities of the PHS that are of crucial importance to a strong and vital health care system in the United States.

Mr. Chairman, I appear before you today to discuss the Coalition's serious concerns with the Administration's budget request for the PHS for Fiscal Year 1989. Preliminarily, I would like to express gratitude for the support that the members of this Subcommittee have shown for the PHS's programs. These programs, which range in mission and character from biomedical and behavioral research to assistance for students in all areas of health professions education, are the backbone of our system of health promotion and disease prevention and treatment. In past years, this Subcommittee has seen fit to approve significantly higher levels of funding for the PHS than the Administration has requested. We hope that you will do so again. We recognize that, as in years past, there is more demand than there are resources. However, we believe that there can be no more deserving cause than protection of the health of our nation by building upon the enormous strides being made in the areas of biomedical research and training. These vital programs will suffer, however, if we do not act now to increase the level of discretionary health spending to an acceptable level. The President has requested $12.75 billion in spending for discretionary health programs. This amount will simply maintain the FY 1988 appropriated levels of spending for these programs. Maintenance of programs is unacceptable; we must move forward. The Coalition, therefore, requests a $2 billion increase over the President's budget request for discretionary health programs. Without these additional funds, the Coalition fears that the nation's health system will be seriously jeopardized.

AIDS

The Coalition applauds the President's increased awareness and commitment to the AIDS epidemic. We, as a nation, must do everything we can to combat the AIDS crisis. Efforts are underway throughout the Public Health Service to do so: The National Institutes of Health ("NIH") is vigorously pursuing treatments and a cure for this disease; the Alcohol, Drug Abuse and Mental Health Administration ("ADAMHA") is studying the behavioral aspects of the disease; the Centers for Disease Control has been the source of epidemiological data by which the spread of AIDS has been tracked and monitored, and has been in the forefront of the PHS's efforts to institute public health measures to halt the progress of AIDS among high risk populations; and the Health Resources and Services Administration has also allocated some resources to train health professionals to understand and care for patients afflicted by AIDS.

This unprecedented response by a variety of PHS agencies to the AIDS emergency would not have been possible if Congress had not maintained these programs at a level of funding that allowed them to remain fully responsive.

Non-AIDS Programs and Activities

While the battle against AIDS continues to be a major priority of the nation, we are firm in our belief that funding for AIDS research and training must not be at the expense of activities in other crucial areas. The Coalition will not support an increase in AIDS funding to the detriment of other equally important programs. While AIDS is clearly the nation's number one health concern for which substantial funds must be appropriated, the money must not be diverted from other vital programs.

The Coalition's proposal would allow an increase in AIDS funding, while permitting the nation to avoid the pitfalls of falling seriously behind in eradicating various childhood diseases, training health professionals in shortage areas, reducing the incidence of communicable diseases, and finding cures for various chronic diseases as well as providing basic primary health care to our neediest citizens. We believe that the PHS programs continue to represent an unsurpassed investment in the future of the citizens of this country.

Our praise for this Subcommittee and the PHS is not meant to obscure the fact that many programs are under-funded or could make even greater strides if provided with increased appropriations. The health service programs in particular, Community and Migrant Health, Maternal and Child Health, and Family Planning continue to be faced with an increase in patient needs that can only be addressed if there are sufficient funds. And our potential for biomedical and behavioral research breakthroughs is seemingly limited only by our investment of funds.

We are also concerned that funding for health professions training has dropped dramatically since 1979. As a result, nursing education, public health, health administration, student assistance and primary care programs have been limited in their ability to respond to emerging needs and priorities by a lack of available funds, such as the nursing shortage. We hope that in FY 1989 this trend can be reversed and adequate funds appropriated to ensure real growth in all the PHS programs, including health professions. Finally, the many programs funded under the auspices of the PHS that focus their efforts on preventing disease and disability merit special attention and commitment because they have the greatest potential to save health dollars and, most importantly, lives.

Coalition Recommendations

The Coalition's recommended funding levels would:

- Allow for expanded research, prevention, and other related activities connected with the battle against AIDS without reducing expenditures to other vital health programs.
- Allow the Centers for Disease Control to continue to immunize children at the FY 1988 level and to provide funds for the vaccine compensation program.
- Provide continued support for the research project grants funded through the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration. There, investigator initiated projects remain the cornerstone of the nation's biomedical and behavioral research efforts.
- Expand the modest federal investment in health professions education, student assistance (HEAL, HPSL), medical/dental primary care training, nurse training, public health and preventive medicine, and disadvantaged and minority student support (EFN, HCOP); as well as provide additional funds for maternal and child health, community health centers, migrant health and black lung clinics.
- Enhance the infrastructure and resources that underlie NIH and ADAMHA funded research. There, resources include research training and career development, particularly for physician researchers, state of the art equipment, and expanded and upgraded research facilities. The absence of a renewed federal investment in the research infrastructure will jeopardize the capability of the nation's research institutions to develop and pursue current and future scientific opportunities.
- Enable NIH to further its efforts in the area of clinical research by providing additional support for research centers, including the general clinical research centers program, and by funding additional clinical trials on exciting new potential therapies. Such clinical research represents a vital and necessary link in the movement of knowledge from the laboratory to the bedside.
- Address the fact that shortages still exist nationwide for several of the health professions, especially in nursing, medical/dental primary care, public health, pharmacy, optometry, and podiatry, among others.
- Allow ADAMHA to begin to implement two exciting and long-awaited initiatives: "The National Plan for Schizophrenia" and the "Decade of the Brain." ADAMHA has completed its congressional mandate to assess its current level of effort with regard to schizophrenia and the neurosciences, and this recommendation represents a first step toward necessary growth in these areas.

- Allow CDC to expand its efforts at controlling the epidemic of sexually transmitted diseases in this country. In addition, it would allow continued funding for the prevention centers, expansion of a federal program for injury prevention, and continued support to state and local health departments for preventive health services.
- Augment previous levels of federal support for programs administered by the Office of the Assistant Secretary for Health which includes health services research, family planning, and health promotion and disease prevention.
- Allow CDC to continue providing support and assistance to state and local programs that prevent and control chronic and environmental conditions such as diabetes, malnutrition, birth defects, toxic waste spills, and radiation releases and protect the health and safety of workers in this country.
- Expand the nation's capacity to organize and deliver primary health care services to all Americans.
- Ensure a sufficient level of financial student assistance to enable the training of health professionals in short supply (e.g., nurses, epidemiologists, gerontologists, and environmental toxicologists).

Again, Mr. Chairman, on behalf of the Coalition for Health Funding, I thank you for your leadership and concern for the many programs that make up the PHS. I would be pleased to answer any questions that you or other members of the Subcommittee might have.

Senator CHILES. Thank you very much.

We note that health programs are tremendously important and we agree. I think history shows that since 1981, basically where discretionary spending has trended down in this administration, health programs have not, and that has been because Congress has seen fit to send a number of dollars in pressing times to that. I think we will try to continue.

Mr. FRIEL. We are very cognizant of that, Senator, and we appreciate your support.

STATEMENT OF JUDITH ROTH, ON BEHALF OF PAUL RYAN, DIRECTOR OF PUBLIC AFFAIRS, THE AMERICAN ASSOCIATION OF OCCUPATIONAL HEALTH NURSES

Senator CHILES. Now we will hear from Mr. Paul Ryan, director of public affairs of the American Association of Occupational Health Nurses.

Ms. ROTH. Good morning, Mr. Chairman. I am Judith Roth, representing the American Association of Occupational Health Nurses.

Senator CHILES. Thank you. I had wondered if you were Paul Ryan.

Ms. ROTH. Not quite. [Laughter.]

The American Association of Occupational Health Nurses appreciates the opportunity to bring to this committee our concerns about workplace safety and health and the role of the occupational health nurses in providing workplace health care.

We are requesting the members of the Senate Labor, Health and Human Services, Education and Related Agencies Appropriations Subcommittee to provide sufficient funding for the National Institute on Occupational Safety and Health to employ additional occupational health nurses in policymaking positions and to fund appropriate education and research for occupational health nursing.

Occupational health nurses are the largest group of health professionals in the workplace. In the majority of work settings, occupational health nurses are the only on-site health professionals.

These nurses have a key role in implementing and managing comprehensive, cost-effective occupational health and safety programs and in achieving health care cost containment.

Occupational health nurses provide direct, hands-on care at the worksite, consistent with the intent of Congress, with the establishment of the Occupational Safety and Health Administration.

Despite occupational health nurses being the largest group of worksite health care professionals, they are underrepresented at NIOSH.

AAOHN can only identify one occupational health nurse in a policymaking position at NIOSH. This one nurse does a commendable job. However, there is a limit to the impact that one person can have in such a large agency.

This results in a lack of understanding of how health services are implemented at the worksite, with a corresponding reduction in effective care for workers.

Lack of occupational health nursing personnel at NIOSH cause concern in the following areas:

In the educational resource centers and policymaking, where ERC's were established to provide education for four disciplines—industrial hygiene, safety, nursing, and medicine. No ERC director is a nurse, thus limiting nursing input into planning and resource allocation.

In the area of personnel planning. A 1987 environmental health manpower report on supply, demand, and projected need for occupational health professionals contained erroneous data about occupational health nursing. Any planning or policy based on this data will be in error.

In the area of education, the nursing programs funded by NIOSH are graduate programs. Seventy-nine percent of the registered nurses practicing in occupational health settings do not have baccalaureate degrees. They are prepared, rather, at the diploma or associate degree level and are not eligible for admission to graduate programs. The majority of students in graduate nursing programs funded by NIOSH do not have an occupational health background.

AAOHN understands that Congress funded the NIOSH educational resources to provide educational opportunities for practicing occupational health and safety professionals.

AAOHN's position is that additional emphasis and funding should be placed on affordable, accessible, baccalaureate completion programs, and continuing education for practicing occupational health nurses.

In the area of research, 20 percent of NIOSH grant funds currently go to nursing, both for research and education. How and where the research funds are directed and their results are unknown.

In the area of consultation, additional occupational health nursing personnel are needed to provide consultation to OSHA as well as to the State health departments in addressing areas of serious workplace health problems.

PREPARED STATEMENT

In summary, these proposals for additional nurses to help set policy and for additional funding for education and research will enhance the ability of the occupational health nurse to have a positive influence on worksite safety and health. The ultimate result will be containment of spiraling health care costs and improved health of the work force, the Nation's most valuable resource.

Thank you, Mr. Chairman.

If you have any questions, I would be glad to address them.

Senator CHILES. Thank you very much. We appreciate the work that you all do.

Ms. ROTH. Thank you.

[The statement follows:]

STATEMENT OF THE AMERICAN ASSOCIATION OF OCCUPATIONAL HEALTH NURSES

The American Association of Occupational Health Nurses (AAOHN) appreciates the opportunity to bring to this committee our concerns about workplace safety and health and the role of occupational health nurses in providing workplace health care.

We are requesting members of the Senate Labor, Health and Human Services, Education and Related Agencies Appropriations Subcommittee to provide sufficient funding for the National Institute for Occupational Safety and Health (NIOSH) to employ additional occupational health nurses in policy setting positions and to fund appropriate education for occupational health nurses.

Occupational health nurses are the largest group of health professionals in the workplace. AAOHN has documented that in the majority of their work settings (65-75%), occupational health nurses are the sole onsite health care professionals. These nurses have a key role in implementing and managing comprehensive cost-effective occupational health and safety programs and in achieving health care cost containment.

Occupational health nurses provide direct care for ill and injured workers, health (medical) surveillance, safety and prevention services for a safe and healthy workplace, health promotion and risk reduction for general good health of workers. Many occupational health nurses provide leadership and management for complex occupational health programs.

A primary goal for occupational health nurses traditionally has been health promotion and disease prevention. Surgeon General C. Everett Koop, emphasized the importance of these services in a recent statement that the worksite is the ideal setting for health promotion/education programs.

Occupational health nurses, in providing the direct "hands-on care" at the worksite, are congruent with the intent of Congress which established the Occupational Safety and Health

Administration to provide a safe and healthy environment for the nation's workers.

Despite the fact that occupational health nurses are the largest group of health care providers at the worksite, they are underrepresented at NIOSH in planning and funding for education, research and other programs. AAOHN can identify only one occupational health nurse in a policy making position at NIOSH. This one nurse does a commendable job. However, lack of additional occupational nursing staff severely limits the ability of NIOSH to adequately plan and allocate resources for this large segment of worksite health care providers. This in turn reduces the effectiveness of the health services provided for workers.

Donald Millar, M.D., Director of NIOSH has stated there are three nurses in policy making positions in NIOSH. However, AAOHN has been unable to determine who two of these individuals are. To date there has been no contact with the occupational health nursing community by these two individuals. AAOHN is pleased to note that an outstanding occupational health nurse has just been appointed to the NIOSH Board of Scientific Counselors.

Lack of occupational health nursing personnel at NIOSH causes concerns in several areas. These are discussed in the following paragraphs.

Educational Resource Centers (ERC) Policymaking - The ERC's were established to provide undergraduate, graduate and continuing education for four occupational health disciplines - industrial hygiene, safety, nursing and medicine. No ERC director is a nurse, thereby limiting the imput of nursing into planning and resource allocation in these centers.

Personnel Planning - A 1987 Environmental Health Manpower Report concerning supply, demand and projected need for occupational health professionals contained totally erroneous data about occupational health nursing. The source of the information is unknown as there was no occupational health nurse on the committee preparing the report. It is obvious that any policy or plan based on this data will be in error.

Education - Approximately 20 percent of the grant budget of NIOSH is allocated to nursing programs. However, these are all graduate nursing programs.

Data collected by AAOHN indicates that 79 percent of registered nurses practicing in the occupational health settings are prepared at the diploma or associate degree level, and therefore are not eligible for admission to graduate programs. As a result, the majority of students in graduate nursing programs funded by NIOSH do not have an occupational health nursing background. It is AAOHN's understanding that Congress funded the NIOSH Educational Resource Centers to provide educational opportunities for practicing occupational health and safety professionals.

AAOHN's position is that educational grant funds should also be used to meet the needs of those professional nurses providing health care for the nation's workers. Additional emphasis and funding should be placed on affordable, accessible baccalaureate completion programs for these practicing occupational health nurses.

Most continuing education offerings by NIOSH have not moved beyond basic theory/update information. Lack of nursing personnel also limits the ability to coordinate these offerings, provide information about their availability, or provide sufficient numbers of courses. The increasing technologic and regulatory complexity of the work environment demands continuous expansion of practitioners' skills and knowledge in order to ensure safety and health in the workplace.

Research - Nursing research expertise is needed at NIOSH to provide direction and coordination for funding and to ensure that the research is consistent with national objectives. The National Center for Nursing Research has recently been funded and has requested input into determining priorities. AAOHN is developing a research agenda to set directions for occupational health nursing research. This agenda will be forwarded to the National Center.

Dr. Millar has stated that 20% of NIOSH grant funds currently go to nursing, both for research and education. How and where these funds are directed and the results of the research are largely unknown.

Occupational health nursing research has the potential to provide answers to some of the most vexing problems in health care today. For example, what interventions are effective in changing lifestyle behaviors contributing to the spread of human immunodeficiency virus (AIDS) infections? What methods will bring about changes in the behavior of health care workers to reduce their risk of contracting bloodborne diseases eg. Hepatitis B or AIDS? Support for these types of nursing research at the policymaking decision level is vital.

Consultation - Additional nursing personnel are needed at NIOSH to provide consultation. Currently there is no consultation assistance to state health departments, most of which have no occupational health nursing expertise on staff.

OSHA is not a health agency. However, it is charged to ensure safety and health in the workplace. Nursing personnel in NIOSH are needed to help OSHA address serious workplace health problems such as the bloodborne diseases, surveillance for and prevention of hazardous exposures, and work related injuries.

In summary AAOHN believes the proposal for additional nurses in policy making and planning positions and additional funding for education and research will enhance the ability of occupational health nurses to have positive impact on worksite safety and health. The ultimate results will be containment of spiraling health care costs and improved health of the work force - the nation's most valuable resource.

STATEMENT OF ROLAND GARDNER, EXECUTIVE DIRECTOR, BEAUFORT-JASPER COMPREHENSIVE HEALTH SERVICES, INC., RIDGELAND, SC, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.

Senator **Chiles**. Now we will hear from Mr. Roland Gardner, on behalf of the National Association of Community Health Centers.

Mr. **Gardner**. Mr. Chairman and members of the subcommittee, I am Roland Gardner, executive director of the Beaufort-Jasper Comprehensive Health Services in Ridgeland, SC.

I am also speaking on behalf of the National Association of Community Health Centers, which represents over 600 community and migrant health centers across the country.

As you know, these centers provide basic health care to America's poorest, most disadvantaged people—people from inner city ghettos to rural migrant farmworker labor camps, to resource-poor communities, including the homeless and substance abusers.

Two of the counties in which Beaufort-Jasper serves have the highest infant mortality rates in the State. In an attempt to address the problem, Beaufort-Jasper entered into a contractual agreement with the department of health and environmental control, which is the health department, to provide perinatal care to women at risk, both high and low risk.

Needless to say, few programs have made as significant impact and contribution to lower income families as cost effectively or in as high a quality manner as community and migrant health centers. The need to strengthen the capacity of health centers is growing more urgent in recent years, as the number of families living in poverty and without health insurance has grown and the number of elderly Americans, unable to afford the high cost of medical care, has increased.

Recognizing the value, cost effectiveness, and quality of services provided at community health centers, the Senate authorizing committee, with broad and bipartisan support, has unanimously approved legislation which would reauthorize the Community Health Center Program at $500 million and the Migrant Health Program at $52.4 million for fiscal year 1989.

These increases in funding over the fiscal year 1988 levels are the strongest possible indication of a desire to significantly increase the ability of health centers to respond to the skyrocketing need, and, in particular, the need to provide comprehensive case managed care to low income, high risk pregnant women and children.

I understand that H.R. 4503 has been introduced and, again, has gotten bipartisan support.

Mr. Chairman, we urge your support for the following recommendations:

Funding for community health centers at $460 million.

This amount would permit current services to continue, as well as allow for a 3- to 4-percent annual real growth, and will provide for service to an additional 500,000 medically underserved patients for fiscal year 1988.

For migrant health, we recommend $52.4 million. This amount would allow for current services to approximately 550,000 migrant farmworkers and their families who, because of their highly mobile lifestyle, face numerous social, cultural, and linguistic barriers which often preclude their ability to access regular comprehensive care.

For the National Health Service Corps—Field Placement Program—we recommend $65 million.

This amount would provide continuation of funding for the private placement practice option at community and migrant health centers as well as National Health Service Corps salaried placements.

In particular, the newly created loan repayment program and the one-time amnesty effort authorized by Congress last year would allow for placements in health centers located in areas with substantial infant mortality rates.

For the National Health Service Corps Scholarship Program, we recommend $5 million.

For the National Health Service Corps loan repayment State demonstration project, we recommend $10 million.

We strongly urge your support of the Stewart B. McKinney Homeless Assistance Act at the expected authorization level of $62.1 million.

PREPARED STATEMENT

Mr. Chairman and members of the subcommittee, I deeply appreciate the opportunity to present this information to you today, and I will be happy to answer any questions you may have.

Senator CHILES. We thank you for your testimony, and we think your health centers are tremendously effective. We will see what we can do.

Mr. GARDNER. Thank you.

[The statement follows:]

STATEMENT OF ROLAND GARDNER

My name is Roland Gardner, Executive Director of the Beaufort-Jasper Comprehensive Health Services, Inc. based in Ridgeland, South Carolina. I am speaking on behalf of the National Association of Community Health Centers, Inc. which represents over 600 Community and Migrant Health Centers throughout our nation. As you know, these centers provide basic health care to America's poorest, most disadvantaged people from inner-city ghettos to rural migrant farmworker labor camps and isolated, resource-poor communities, including the homeless and substance abusers. I also intend to speak to you on the newly created homeless health care services.

I deeply appreciate the opportunity to discuss with you today the problems which these health centers face in the current economic climate and the issue of FY 1989 funding for these federal programs.

I. Community and Migrant Health Centers and Related Programs

Overview

Health centers are primary care facilities which provide out-patient medical and health services to over 6 million low-income and disadvantaged patients each year, most of whom have no other available source of health care. These include medically (and, often, economically) indigent persons who lack public or private coverage -- including significant numbers of high-risk pregnant women and children and homeless persons -- as well as Medicare and Medicaid recipients refused care by other private providers (often because of low payment rates or discriminatory practices). In many rural communities, these centers are the only available health care providers for miles.

Nearly 20 million other Americans in need of basic health care are not served by these programs due to funding constraints.

Few programs have made as significant a contribution to low-income families as cost effectively, or in as high quality a manner, as have Community Health Centers. The need to strengthen the capacity of health centers has grown more urgent in recent years, as the number of families living in poverty and without health insurance has grown and the number of elderly Americans unable to afford the high cost of medical care has increased. For millions of our most vulnerable citizens, health centers are increasingly becoming their only source of health care.

The patients who currently use their services tell much of the story:

- Nearly 70 percent are members of a minority group (minorities suffer serious health disadvantages, both in their health status and in their access to care).

- Over 60 percent of the health center users have family incomes below the federal poverty level (the poor are significantly less likely to receive necessary care because of financial barriers).
- Over one-third of our patients are children under 14 years, and more than one-fourth are women of childbearing age. (Poor children are at special risk as they are likely to be uninsured and without a regular source of health care, and poor pregnant women are much less likely to receive prenatal care.)
- 58 percent of health centers users are uninsured; only 25% are eligible for Medicaid. (Uninsured people are much less likely to have a regular source of health care, or to obtain care when they need it).

Health centers are clearly serving the poor and uninsured, whose numbers have increased dramatically in recent years. These trends have been accompanied by deep reductions in our major public health programs.

Health centers are effective in several key ways.

- They are responsive to their communities - centers receive a high degree of acceptance and utilization in communities they serve.
- They have been effective in persuading poor families to end their reliance on expensive and less appropriate hospital emergency rooms, and to make use of preventive health services and habits.
- They have significantly improved the health of the communities they serve: Major reductions in infant mortality - as much as 40 percent - have been achieved in areas served by health centers, due to the access they provide to high quality maternity and infant care services.

Health centers provide high quality care, including clinical management of patients, completeness of care, and follow-up. They are efficient as well: Between 1974 and 1983 health centers increased the population they served by more than 300 percent, even though their grant funding levels grew by only 65 percent. Health centers have become more efficient at generating other revenues, and make more judicious use of ancillary services (laboratory, x-ray, pharmacy) than do other providers.

By encouraging the appropriate use of health care, health centers have increased access to care without encouraging overuse. Health centers dramatically reduce hospital use and costs for patients.

- Centers have reduced admission rates by between 20 and 70 percent, and shortened the lengths of stay for their patients, without sacrificing the quality of care.
- Most dramatically, centers have saved the Medicaid program the equivalent of 40 percent per year in costs per recipient.

These characteristics make Community and Migrant Health Centers extraordinarily effective providers for low-income families otherwise barred from receiving adequate medical care because of geographic, financial or cultural barriers. In an era of widespread need and serious financial constraint, these health centers make tremendous sense. Health centers save both lives and dollars in an effective, efficient and high quality fashion. We simply cannot afford not to invest in health centers.

Despite the fact that there has been a dramatic increase in the number of poor and uninsured population to be served, the funding which health centers has received since 1981 has not kept pace with the need or the rising costs of health care.

For FY 1988, Community and Migrant Health Centers received actual funding cuts as follows:

- Community Health Centers - $25 million
- Migrant Health Centers - $2 million

These amounts were reduced from a level of funding which has been held constant for the past 3 years. Furthermore, the loss of these funds mean that substantial cuts in health services for the poor and uninsured will be unavoidable. Already health centers around the country are experiencing 5-20% reductions in funding. Therefore, at the reduced FY 1988 funding levels, it will be necessary to close over 100 health clinic sites and terminate services to more than 300,000 patients.

I understand that the House Appropriations Committee has already considered supplemental FY 1988 appropriation legislation and has decided not to include restoration funding for the health center programs. I can only tell you that I and my colleagues are deeply disappointed in that decision because of the great harm that the funding reductions are causing for the people we serve. I wish to express the hope that this Subcommittee will seriously consider and act on supplemental funding for Community and Migrant Health Centers.

Recognizing the value, cost effectiveness, and quality of services provided at health centers, the Senate authorizing subcommittee, with broad and bipartisan support has unanimously approved legislation which would reauthorize the Community Health Center program at $500 million and the Migrant Health program at $52.4 million for FY 1989. These increases in funding over FY 1988 levels is the strongest possible indication of a desire to significantly increase the ability of health centers to respond to the skyrocketing need, and in particular, the need to provide comprehensive case managed care to low-income, high-risk pregnant women and children.

I understand that authorizing legislation, H.R. 4503, has been introduced in the House which would also permit increased funding for Community and Migrant Health Centers in FY 1989, and we are told that this will also have broad and bipartisan support.

In sum, Congressional recognition of the outstanding work of Community and Migrant Health Centers, as well as the pressing need to reach out and serve more of the millions of medically indigent and underserved Americans is evident in these two pieces of legislation.

Recommendations

1. Community Health Centers - $460 million

This amount would allow for current services as well as to allow 3 to 4 percent annual "real" growth, and would provide for service to an additional 500,000 medically underserved patients over FY 1988 levels. In addition, health centers need resources to meet the demands of:

- the soaring malpractice cost facing them, despite the fact that health centers have an outstanding record of almost no claims being filed against them.
- providing health care to an increasing number of high-risk patient populations, such as AIDS patients and substance abusers. Health centers are seeing a large increase in the number of AIDS patients being served. This is very costly and health centers need the resources to deal with the problem effectively.
- recruiting and retaining clinical staff given the fact that health centers can do nothing about their geographic isolation even if they wanted to.

We are very pleased that the Congress decided to fund the Infant Mortality Initiative. It is a very important step to reducing the high rate of infant mortality in the United States. However, even by using the Administration's request, the amount provided last year will only serve an additional 25,000 patients. This is a minuscule portion of the over 2 million women who become pregnant each year.

Our recommendation would allow service to another 31,250 pregnant women, i.e., over 6,000 more than were served in FY 1988.

2. Migrant Health - $52.4 million

This amount would allow for current services to approximately 550,000 migrant farmworkers and their family members, who, because of their highly mobile lifestyle, face numerous social, cultural and linguistic barriers which often preclude their ability to access regular, comprehensive health care.

Furthermore, with the newly legalized population resulting from passage of the Immigration Reform and Control Act of 1986, health centers are faced with addressing the health care needs of these special populations. This amount would also allow an increase of about 2% over current services and would provide for an increase in service to approximately 50,000 farmworkers.

3. National Health Service Corps (Field Placement) - $65 million

This amount would provide continuation of funding for the private placement (PP) assignments at Community and Migrant Health Centers, as well as NHSC federally-salaried placements. In particular, the newly created loan repayment and the one-time amnesty effort authorized by Congress last year would allow for placements in health centers located in areas with substantial infant mortality rates and which have a dire need for additional obstetrical clinical personnel.

As you know, the NHSC is the single major supply source of clinical manpower for health centers and especially in those areas which simply cannot recruit doctors, either because of their locations or because the area is economically depressed. Furthermore, the Administration's request for this program reflects no amount for the amnesty program which was established by the Congress last year.

There will be 2,258 NHSC assignees in the field in 1989. More than 1,200 of these will be at health centers. Through the assistance of the NHSC the number of patients being served has increased.

I might note that health centers have borne a significant share of the costs associated with their NHSC assignees. If these individuals had been placed under federal employment, the additional costs to the NHSC program would exceed $80 million this year alone.

4. NHSC Scholarship Program - $5.0 million

We wish to strongly recommend continued funding for the Scholarship program which has been drastically cut back over the past few years and deleted this year.

As you know, the Scholarship program has assisted students who would likely never qualify for commercial -- or even governmental -- loans. Many NHSC Scholarships go to students who first entered medical and dental training under the Exceptional Financial Need program, which targets disadvantaged and minority students. In fact, the recent notable decline in minority and low-income medical school enrollment can be tied directly to cuts in the NHSC Scholarship program. Our recommended funding level would support 200 Scholarships in FY 89.

5. NHSC Loan Repayment/State Demonstrations - $10 million

As mentioned before, since 1982, the NHSC Scholarship program has been severely reduced. Furthermore, recent studies indicate that there is a severe shortage of doctors in medically underserved and rural areas. Therefore, doctors are urgently and immediately needed in these areas.

The amount recommended would allow for $9 million to be used to enroll approximately 150 individuals for three-year commitments to serve in medically underserved areas; the other $1 million would be used for the new state demonstration programs.

The Loan Repayment program is desperately needed because:

- It would provide an immediate supply source for C/MHC and others in shortage areas; unlike the Scholarship program, the Loan Repayment program could seek applications from students who have already completed, or are near the completion of, their training -- thus there would no lag time in making these individuals available for service.
- It would provide greater assurance that the recipients will complete their service obligation: Because it would attract applicants who are near to or at completion of their training, the likelihood of "defaults" (caused mainly by significant changes in personal circumstances over the education/training period) would be dramatically reduced.

II. Homeless Health Services

Overview

In 1987 the Stewart B. McKinney Homeless Assistance Act created a new Section of the Public Health Service Act (Section 340) which established a Health Services for the Homeless Program. The Health Services for the Homeless Program provides primary health care, substance abuse, and -- at the option of the grantees -- mental health services for homeless persons and families. The new program is administered through the Health Resources and Services Administration's Bureau of Health Care Delivery and Assistance (BHCDA). The Program was based on the successful outreach-oriented health care for the homeless service models demonstrated in 19 cities through four-year funding from the Robert Wood Johnson Foundation and the PEW Memorial Trust. These projects had not surprisingly, revealed a pool of untreated health problems unparalleled in the general population and, perhaps mere importantly, demonstrated that homeless people could be accessed into health care through appropriately staffed, outreach-oriented programs using a case-managed approach to health care.

In FY 1987, Congress appropriated spending for the Program at $46 million, which was obligated by BHCDA to 109 grantees across the country by January 1, 1988. The grantees moved swiftly to initiate delivery of services to an estimated 400,000 persons on an annualized basis, thus meeting about 20% of need among the estimated homeless population. Disturbingly, only $14.4 million in funds were appropriated for FY 1988, a drastic 68% drop in appropriations for the Program below the FY 87 level. BHCDA has announced that it plans to utilize the FY 88 funds only to provide for continuation of currently-funded projects on a competitive basis in order to help them stay in business beyond one year.

It is extremely important to note, however, that for FY 1989, the current services level for the program is $46 million plus an estimated $7 million required to offset the imminent loss of private foundation funding and continue current services at the 19 demonstration projects on whose success the national program is modeled. Equally important, only 109 of 150 applicants received funding in the first funding cycle; 40 cities with populations above 100,000 did not receive funding; and not more than ten of the projects funded out-reach to provide services to homeless persons and families in rural communities due to the short (six-week) time frame BHCDA provided in which to respond to the request for proposals and inaccurate information that discouraged applicants from rural communites during the first funding cycle.

The Senate Committee on Labor and Human Resources has already approved legislation reauthorizing the Health Services for the Homeless Program at $61.2 million in FY 1989, with further increases in FYs 1990 and 1991; and two separate bills (H.R. 4003 and H.R. 4352) have been introduced in the House with broad bipartisan support, authorizing $61.2 million for the program in FY 1989. In effect, the Senate and House authorizing Committees are on record in recognizing that $61.2 million is required in FY 1989 to continue current services and to allow for a modest number of new starts in communities missed in the first funding cycle.

Recommendation

We strongly recommend that the Congress fully fund this Program at its expected FY 1989 authorization of $61.2 million to continue the current level of services being provided to homeless persons and to enable a modest number of new starts in communities
that can demonstrate need, local resources, and sound program approaches who were missed in the first round of funding. This level of funding will enable local Homeless Health Care projects to serve 530,000 persons or 26%-53% of estimated need next year.

Mr. Chairman and members of the Subcommittee, I deeply appreciate the opportunity to present this information to you today. I will be happy to answer any questions.

STATEMENT OF JAMES G. JONES, M.D., PRESIDENT-ELECT, THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

Senator CHILES. Now we will hear from Dr. James G. Jones, the president-elect of the American Academy of Family Physicians.

Dr. JONES. Mr. Chairman, I am Jim Jones, a country doctor from North Carolina. I am privileged to appear as president-elect of the American Academy of Family Physicians.

The academy represents 60,000 family physicians, students, and residents.

I am especially pleased to appear before this subcommittee today to discuss the important role that Federal funds have had in helping to assure access to health care for the American people.

It is my hope that my testimony will help you in your efforts here in Congress to appropriate funds to continue supporting family practice training programs under title VII.

Mr. Chairman, the American Academy of Family Physicians believes that the goal—and we know that it is one you share—of assuring access to quality health care by the American people can be met only if the supply of family physicians is adequate to meet the demand for those services.

Given the current, significant demands for services of family doctors, the supply we believe will be inadequate without deliberate and targeted efforts to train more family doctors.

This is especially noted, as I am sure you are aware, in the recent, preliminary conclusions of the Council on Graduate Medical Education.

It is our belief, sir, that the Federal investment in family practice, which has been significant, has yielded to date some significant societal benefits, including helping to improve the specialty and geographic maldistribution of physicians.

We would point out that family doctors care for patients in all age groups—we are fond of saying from the cradle to the grave.

A significant portion of the patients cared for by family doctors are the geriatric people and also, more recently, our doctors have played a significant role in the treatment of AIDS.

Family practice residents are more likely to practice in rural and underserved areas than most other physicians are because our practice is usually ambulatory based and it is preventive medicine oriented, to help assure that people will remain active and self-sufficient.

This, however, produces a unique problem for family medicine because, under the current Medicare reimbursement system, which, incidentally, discourages preventive care and reimburses family physicians at less than other specialties, a major contributor to the financial fragility of the family practice education is contained in that situation.

In the past, as I say, you have been very generous under section 780 of the Public Health Service Act, which currently funds at $6.7 million our departments of family medicine, and our residency programs are supported under section 786, at $35.5 million.

We deeply appreciate, sir, the support that this particular subcommittee has given to family practice in the past and look forward to working with you in the future to assure funding for family practice and help meet the goal of access to quality health care for all American people.

PREPARED STATEMENT

Thank you very much for this distinct privilege of appearing before you.

I would be happy to answer any of your questions.

[The statement follows:]

STATEMENT OF JAMES G. JONES

Mr. Chairman, I am James G. Jones, M.D., currently the President-Elect of the American Academy of Family Physicians. The Academy is the medical specialty society which represents over 60,000 family physicians, residents and medical students. It is my pleasure to appear before this subcommittee today to discuss with you the important role of the federal government in helping to ensure access to health care through training of family physicians. I hope that my testimony will encourage you to enact an appropriations bill which funds programs in health professions, and in particular, programs to train family physicians.

Current Funding:

With the support of this subcommittee, family practice programs did well in the Fiscal Year 1988 appropriations process. On behalf of our members, I want to express our sincere thanks to you for your recognition of the positive contribution of the specialty of family practice to the nation's health system.

Section 786 of the Public Health Service Act provides support to family practice residency programs with a set aside of 7.5% of funds appropriated for general dentistry programs. The funding provided for Section 786 in this fiscal year will support approximately 3,800 residency positions, will enhance faculty development programs, and through the predoctoral projects is expected to benefit over 13,000 medical students. The funding level for Section 786 currently is $35,405 million.

Section 780 supports family medicine departments within medical schools. Of the 138 medical schools, 109 now have departments of family medicine and 11 have other administrative entities in family medicine. The $6.7 million appropriated for this section is funding 57 projects and will provide more than 11,000 medical students with exposure to family practice.

The Federal Role:

For two decades the federal government has provided funding to improve access to health care in this country. Initially, the federal support was broad-based, with the objective of improving access through increases in the numbers of physicians trained. With success in achieving growth in the aggregate number of physicians, Congress turned its attention to the more focused problems of specialty and geographic maldistribution. A major policy decision was to use federal funds to encourage growth in the specialty of family practice. Through targeted support at the medical school level aimed at putting departments of family medicine on equal footing with more established medical specialties (Section 780), and through support of family practice residency programs (Section 786), this growth has been significant.

The number of family practice residency programs, which experienced tremendous growth from the inception of the specialty in 1969 until 1982, has now stabilized at approximately 382 programs with 2,456 first year residents. The growth in family practice residency programs began to level off in 1983, paralleling the leveling off of appropriations for family practice training programs.

The plateau in the number of residency programs and positions is accompanied by a projected high rate of retirement from practice by the more than one-third of family physicians/general practitioners age 55 and older. This impending decrease in supply of family physicians is therefore a realistic expectation. These two trends will reduce the number of family physicians in practice at a time when the demand for family physicians is increasing.

Family Practice:

Family physicians provide ambulatory-based, cost-effective, preventive-oriented care to a broad population of this country. According to 1985 data from the National Ambulatory Medical Care Survey (NAMCS), 30.5 percent of visits to office based physicians in the U.S. were to family physicians (Attachment A.).

Because the elderly represent a sizable portion of this population served by family physicians, geriatric health care is an important part of the family physician's training and practice. Care provided by family physicians is aimed at keeping the elderly person active, mobile and self-sufficient. According to NAMCS data, visits to family physicians represented 29.1 percent of the visits to all physicians by the nation's 26.6 million residents age 65 and over (Attachment B). This fact is particularly important for the Medicare program, in view of initiatives to seek alternatives to costly inpatient care and to encourage less expensive, ambulatory based care. In addition to the elderly, data indicate that family physicians care for a significant percentage of the pediatric age population and Medicaid recipients.

Because of their multidisciplinary training, family physicians are able to care for 85 percent of the problems that present in their offices and are particularly adaptable to the diverse needs presented in various geographic areas. Family physicians are continuing to locate in shortage and rural areas thus continuing to address the national problem of geographic maldistribution. Data from the 1986 survey of family practice residency graduates indicate that over 90 percent enter family practice (as opposed to subspecialization, fellowships, etc.) and that over 47 percent locate their practices in rural and suburban communities of less than 25,000 (Attachment C).

I also want to emphasize that family physicians' responsibilities in prevention, patient education, infection control, and treatment of patients affected by HIV infection are growing rapidly. Because family practice is so comprehensive and broad ranging, we have certain key roles in controlling the epidemic, alleviating fears, and providing personal and family care. The Academy currently is developing core curriculum guidelines concerning AIDS for use in family practice residency programs. The family practice community is committed to preparing medical students, residents and practicing family physicians to care for AIDs patients. And we encourage a continuation of the federal commitment to train family physicians who are a national resource to address the AIDS epidemic.

We firmly believe that the development and growth of family practice has helped correct both specialty and geographic maldistribution of physician services. Maintenance of the progress to date and further improvements in these national problems will require continued and intensified federal commitment.

Uniqueness of Family Practice Training:

As a specialty with a unique training model, family practice has been faced with difficult financial constraints. Over two-thirds of these residency programs are located in community hospitals, rather than located in traditional tertiary medical centers. In addition to the community hospitals, family practice residency programs are exploring affiliation with community health centers, migrant health centers and free clinics. Location in non-traditional training sites, coupled with an ambulatory-based training model which emphasizes training in a family practice center to simulate practice in a physician's office, provide family practice residency programs with significant financial challenges.

Studies of these programs indicate a cost distribution of approximately one-third resident salaries/fringe benefits, one-third faculty and administrative costs, and one-third overhead costs of the family practice center. Revenue sources are comprised largely of governmental support, practice revenues and hospital support. Over two-thirds of family practice programs have had federal training grant support. Due to the emphasis on ambulatory and preventive care, reimbursement from Medicare and other third party payors is less than for inpatient, procedurally oriented care. Patient care revenues have been unable to support the training programs, and it appears unlikely that they ever will be able to do so under the current reimbursement structure. Continued and enhanced targeted federal support is essential for family practice programs to continue to thrive.

Summary:

The American Academy of Family Physicians believes that the goal of assuring access to quality health care by the American People can be met only if the supply of physicians is appropriate to meet the demand for services. Given the current demand for services of family physicians, the supply is inadequate and will remain so without deliberate efforts to train more family physicians. We are deeply appreciative of the support that this subcommittee has given to family practice in the past and look forward to continuing to work with you on appropriations for Fiscal Year 1989.

Thank you for the opportunity to share our views with you. I would be pleased to answer any questions at this time.

— Attachment A

II-B-1 NUMBER AND PERCENT DISTRIBUTION OF OFFICE VISITS BY PHYSICIAN SPECIALTY, TYPE OF PRACTICE, AND PROFESSIONAL IDENTITY: UNITED STATES, 1985

Physician Specialty, Type of Practice and Professional Identity	Number of Visits in Thousands	Percent Distribution
TOTAL Visits	636.386	100.0
Family Practice	193.995	30.5
Internal Medicine	73.727	11.6
Pediatrics	72.693	11.4
Obstetrics and Gynecology	56.642	8.9
Ophthalmology	40.062	6.3
Orthopedic Surgery	31.482	4.9
General Surgery	29.858	4.7
Dermatology	24.124	3.8
Psychiatry	17.989	2.8
Otorhinolaryngology	16.097	2.5
Urological Surgery	11.699	1.8
Cardiovascular Disease	10.617	1.7
Neurology	4.992	0.8
All Other Specialties	52.408	8.2
Type of Practice		
Solo	323.653	50.9
Partnership	113.317	17.8
Other[1]	199.416	31.3
Professional Identity		
Doctor of Medicine	600.514	94.4
Doctor of Osteopathy	35.872	5.6

[1] Includes group practice and other.

Source. *U.S. Department of Health and Human Services. Public Health Service. National Center for Health Statistics. 1985 Summary: National Ambulatory Medical Care Survey. January 23, 1987. Number 128. p. 3.*

Attachment B

II-B-2 NUMBER AND PERCENT DISTRIBUTION OF OFFICE VISITS BY SEX AND AGE OF PATIENT AND BY FAMILY PHYSICIANS AND OTHER PHYSICIANS: UNITED STATES, 1985

Sex and Age of Patient	All Physicians		Family Practice Physicians		Other Physicians[1]	
	Number of Visits in Thousands	Percent Distribution	Number of Visits in Thousands	Percent Distribution	Number of Visits in Thousands	Percent Distribution
TOTAL	636,386	100.0	193,995	100.0	442,391	100.0
Female						
TOTAL Female	387,481	60.9	117,685	60.7	269,795	61.0
Under 15 years	58,175	9.1	14,699	7.6	43,475	9.8
15-24 years	48,883	7.7	16,679	8.6	32,204	7.3
25-44 years	118,557	18.6	35,797	18.5	82,760	18.7
45-64 years	82,331	12.9	26,915	13.9	55,416	12.5
65 years and over	79,535	12.5	23,595	12.2	55,940	12.6
Male						
TOTAL Male	248,906	39.1	76,310	39.3	172,593	39.0
Under 15 years	60,594	9.5	14,960	7.7	45,633	10.3
15-24 years	25,081	3.9	9,672	5.0	15,408	3.5
25-44 years	57,167	9.0	20,251	10.4	36,917	8.3
45-64 years	55,060	8.7	17,081	8.8	37,978	8.6
65 years and over	51,004	8.0	14,346	7.4	36,657	8.3

[1] Excludes physicians in anesthesiology, pathology or radiology.

Source: *U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, National Ambulatory Medical Care Survey, unpublished data.*

— Attachment C

APPENDIX B, Education

REPORT ON SURVEY OF 1986 GRADUATING FAMILY PRACTICE RESIDENTS

The total number of graduates surveyed was 2.306. Of this number, 1.868 (81%) responded. Of these respondees, 1.861 indicated the type of practice arrangement and 1.595 specified the size of the community in which they plan to serve. A summary of the results as of July 1986 follows.

The data from 1977, 1978 and 1979 has been reanalyzed to conform with the 1980-1986 statistics. Caution must be exercised in comparing data previous to 1977 because of changes made to data analysis. However, the revised 1977-1979 data may be directly compared with the 1980-1986 data with confidence.

Practice Arrangements of 1986 Graduating Residents

Type of Practice Arrangements	*Number of Reporting Grads*	*Percentage of Total Reporting Grads*
Family Practice Group	457	24.6%
Multi-Specialty Group	202	10.0%
Two-Person Family Practice Group (Partnership)	277	14.9%
Solo	191	10.3%
Practice (arrangement not specified)	78	4.2%
Military	139	7.5%
Teaching	37	2.0%
USPHS	185	9.9%
Emergency Room	82	4.4%
Hospital Staff	25	1.3%
Research	8	.4%
Administrative	0	.0%
Further Training	32	1.7%
Fellowship	53	2.8%
None of the Above	95	5.1%
	1.861	100.0%

Distribution of 1986 Graduating Residents by Community Size

Character and Population of Community	*Number of Reporting Grads*	*Percentage of Reporting Grads*	*Cumulative Percentage of Total Reporting Grads*
Rural area or town (less than 2.500) not within 25 miles of large city	153	9.6%	9.6%
Rural area or town (less than 2.500) within 25 miles of large city	65	4.0%	13.6%
Small town (2.500-25.000) not within 25 miles of large city	321	20.1%	33.7%
Small town (2.500-25.000) within 25 miles of large city	218	13.7%	47.4%
Small city (25.000-1000.000)	264	16.6%	64.0%
Suburb of small metropolitan area	63	3.9%	67.9%
Small metropolitan area (100.000-500.000)	170	10.7%	78.6%
Suburb of large metropolitan area	183	11.5%	90.1%
Large metropolitan area (500.000 or more)	119	7.5%	97.6%
Inner city/low income area (500.000 or more)	39	2.4%	100.0%
	1.595	100.0%	

Senator CHILES. Dr. Jones, we are delighted to have you appear before us. Family practice we think is tremendously important in trying to assure that we are going to have enough doctors, especially looking at our aging population, and knowing that family practitioners serve that population.

Dr. JONES. We are very grateful to you for that consideration, Mr. Chairman.

We agree with you that the proposed budget by the administration is woefully lacking in support of graduate education in general and family medicine in particular.

Senator CHILES. Sir, we appreciate your statement. Thank you.

STATEMENT OF GARY FILERMAN, PH.D., PRESIDENT, THE ASSOCIATION OF UNIVERSITY PROGRAMS IN HEALTH ADMINISTRATION

Senator CHILES. Now we will hear from Dr. Gary Filerman, president of the Association of University Programs in Health Administration.

Dr. FILERMAN. Senator, I am Gary Filerman, with the Association of University Programs in Health Administration.

We are here to request continuation of the only—the only—Federal investment in management development in the health services, which is a small, $2 million, item in the health manpower bill, of which $1.5 million goes into program development and $500,000 goes for student support, most of which is focused on mid-career students.

Let me tell you what that means in Florida.

It may be a surprise to you to know that in the State of Florida, there are less than 100 people trained in health care management a year. We have one, small, accredited program at Gainesville, and in south Florida, which is one of the most bustling health care environments in this country, there is no accredited program in health care administration and two small startup programs, one at FIU and one at the University of Miami.

Now, in the State, there are serious managerial, underserviced problems in HMO, with which I know you are very familiar. We have serious problems in the long-term care area. There are very few trained managers in the long-term care, nursing home system. There are very few trained managers in home health agencies.

Rural hospitals in the State of Florida have a very difficult time attracting anybody with management training appropriate to health. And the AIDS situation in south Florida can very well be described now as primarily a management issue. It is a problem of planning and implementing appropriate services that are humane and cost effective.

That is what health care management is all about.

The training infrastructure for this field is very small and very fragile. That $1.5 million is primarily used for leverage, and we estimate that it's leverage at somewhere of between six and eight to one. It is a very, very good investment.

Barry Green, at Gainesville, has been able to take that small annual grant and parlay that into the development of a policy support program for the State legislature on long-term care. He has been able to develop training programs in the schools of medicine, nursing, and other schools, where health professionals are very much in need of knowing about health economics and cost-effective behavior.

So this investment is a very critical one that gets at a number of soft areas that go across the whole range of Federal investment in health services, and we hope the committee will continue its support for it.

[The statement follows:]

STATEMENT OF GARY FILERMAN

My name is Gary Filerman and I am President of the Association of University Programs in Health Administration.

In the way of background, Mr. Chairman, our Association is an international consortium which includes 47 U.S. graduate schools with a network of collaborating health services, foundations, business organizations, and government agencies. Our primary mission, from the time AUPHA was founded back in 1948, has been to focus the resources of higher education on a single, most important goal -- managing health services with optimum quality, efficiency, and responsiveness.

Mr. Chairman, perhaps the most critical challenge confronting our health care system today is the coordination and management of expensive facilities, personnel, and specialized equipment in ways that will cost effectively serve the health needs of our citizens. Never has that challenge been so great.

In the summer of 1987, the Health Care Financing Administration projected that national health expenditures will grow from the $458 billion spent in 1986 to $1.5 trillion in the year 2000. That will represent 15 percent of this nation's gross national product.

Some of this projected increase is due to inflation. However, a substantial part of the increase is due to the effects of the demographic composition of the population, and how this aging population will simply require and demand more health care services. The federal government will pay a major portion of that bill, one way or another.

This rapidly expanding demand for health care services, coupled with the growing complexity of the health care system, makes it evident that health services administration is one of the critical management assignments in today's society. We ask the health services administrator to respond to our health service needs, but at the same time we ask for a sound stewardship of the community's limited financial resources. That is a tough spot to be in.

As a practical matter, health services administrators are on the front-line, implementing the policies of this and other committees in Congress. They must deal every day with problems of assessing expensive new technologies, aging physical plants, competition, AIDs patient management, nursing shortages, assessing practitioner competence, etc. By making the best use of scarce resources, a good administrator creates the conditions under which health professionals are most productive and both cost control and quality control systems are most effective.

In short, nearly every aspect of health care policy -- including those policies aimed at controlling the burgeoning costs of health care -- ultimately becomes the responsibility of health services administrators. Whether or not they are up to the task will in large measure determine the success or failure of those policies where it counts -- in the community.

Mr. Chairman, I would like nothing better than to tell you that all is well on this score. However, that is not the case.

The fact is that management competence in health services is grossly uneven and, what is more, the problem is growing. As critical as these positions are, as many as two-thirds of the Nation's health administrators have not received adequate training and education for their managerial responsibilities. This is particularly disturbing in light of the projected explosive growth in health services expenditures. Moreover, in the short-term, many of the actions taken in this or previous sessions of Congress will fall short of the intended purpose because the skills to implement them are not in place.

The health professionals whose training and education you have supported will not be fully productive because the settings in which they will work will have been inadequately managed. For example, attempts to resolve problems of geographic distribution are hindered by inadequately managed rural and inner-city facilities. We cannot attract doctors and nurses to organizations which are not well run.

Lastly, cost-containment efforts have limited effectiveness because of the inability of some administrators to install systems to control the use of expensive resources, to deal with the information which they produce, and to properly interpret that information to funders, providers and the community.

Despite the serious, across-the-board need for qualified, professionally trained health administrators, the President's budget once again proposes to terminate the two relatively small, but important programs that go a long way towards meeting the management needs of our health care system.

In past years, this Subcommittee has rejected any attempts to end the federal investment in improving health management competence and for that we are most grateful.

Recommendation

We are here again, Mr. Chairman, not to bust the budget, but to respectfully ask that you continue these programs at the modest levels of $1,500,000 for graduate programs and $500,000 for traineeships. We believe this small investment is paying big dividends in better management of a rapidly expanding health care system.

Senator CHILES. Thank you, sir.

It seems that we are talking about an area here that looks like supply and demand would be requiring that there be more schools and more need for this. They have to be good jobs, many of them, anyway, have to be. I assume that they are being filled now by somebody that you are saying is not qualified and has not gone to school.

Dr. FILERMAN. The most recent study of people in management positions and health services, which was done by the W.K. Kellogg Foundation indicated that something like 75 percent do not have appropriate training for the positions that they are in.

That is a very serious issue in this country. You can't get a trained manager for a nursing home. And nursing home organizations, which have tried to expand, some of the most quality organizations in the country, tell me that their biggest limitation on expansion is that they cannot get quality people to run their organizations.

Salaries are very low.

Senator CHILES. Salaries are low?

Dr. FILERMAN. Yes.

Senator CHILES. It would seem to me, again, that we are talking about a lot of private nursing homes, now. A lot of them are doing very well. I'm not talking about some of the old ones that are out there, and everything. But these new ones that people are creating, you know, they seem to be doing very well. There seems to be a hell of a lot of capital to build them, to put them up, and I see more entrepreneurs getting into that.

Somebody has to be making some money off that. We know that they are billing the Federal Government for a lot of money.

But they are not paying those managers very well, you say? I am just looking at supply and demand and the way economics normally work. If you are fighting to get good managers, I would think you would have to be paying them.

Dr. FILERMAN. The argument that they make is that the margins of profit on reimbursement from Medicare are so low that they are down to calculating a penny per meal on some of these outfits.

Senator CHILES. I know they are working on close margins. But, again, they keep building these things. I keep seeing it in Florida and I see some pretty smart operators getting into it.

Dr. FILERMAN. I think if you look into the distribution of patients in a lot of those institutions, you will find that they are really the upper middle class and middle class patients.

Senator CHILES. I see.

Dr. FILERMAN. But when you get into the other services, for the poorer people, home health agencies, HMO's, rural hospitals, you have a real problem.

Senator CHILES. We thank you for your testimony.

STATEMENT OF ANTHONY J. McNEVIN, PRESIDENT, THE AMERICAN ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE

Senator CHILES. Now we will hear from Mr. Anthony J. McNevin, the president of the American Association of Colleges of Podiatric Medicine.

Mr. MCNEVIN. Good morning, Senator Chiles.

Senator CHILES. Good morning.

Mr. McNEVIN. My name is Anthony McNevin. I am the president of the American Association of Colleges of Podiatric Medicine.

The association represents the Nation's seven colleges of podiatric medicine, one of which is located at Barry University in north Miami, and its affiliated 232 public and private teaching hospitals that offer fourth-year externship and residency training programs, and over 3,000 students and 550 residents.

As you know, Mr. Chairman, podiatric medicine is that profession which deals with the diagnosis, treatment, and prevention of diseases and disorders affecting the lower extremity.

Since the start of this century, science and technology have combined to help us develop a far better understanding of the foot, how it works, and what can go wrong.

Science has determined, for example, that our feet absorb the impact of up to one-half a ton of force every day, and that in the average lifetime our feet carry us an average of 100,000 miles.

All of this activity is dependent upon one relatively small area that contains one-fourth of all the bones in our body, 19 muscles, and 107 ligaments.

Senator CHILES. You're making my toe hurt again. I cut my nails too short and then I started walking and then trying to guard the toe. Now I have everything cramped, and you are hurting me, Doctor. I need your assistance.

Mr. McNEVIN. We can solve your problem, I'm sure. [Laughter.]

Senator CHILES. You are so right. When something goes wrong with your feet, you know it as quickly as anything else because you can't seem to guard it and you can't seem to stay off them. It is a little bit hard around here to cut the toes out of your shoes, which is probably what you would recommend that I do. [Laughter.]

Mr. McNEVIN. The truth of the matter is that we pay little attention to our feet, until something goes wrong, as you suggest.

Senator CHILES. Yes.

Mr. McNEVIN. That something may be the result of a simple strain or hairline fracture, or it could be an early warning sign of some more disorder affecting the body, such as heart disease, diabetes, et cetera.

Mr. Chairman, whether the result is of a disease or a job-related accident or a sports injury, all of us, young and old, are vulnerable to foot problems.

As we know, for example, there are as many as 10 percent of all children suffering from congenital foot problems that can curtail their activities and hamper both their physical and emotional development.

Today, there is an estimated 95 percent of elderly Americans who suffer from foot disorders, and, according to the National Center for Health Statistics, one-fourth of all nursing home residents cannot walk as a result of foot problems.

Mr. Chairman, unless there is an adequate supply of podiatric physicians to meet these needs, many of our elderly will be forced to postpone or forego treatment altogether, only to require more extensive and more expensive care later in life. For these individuals, foot problems will rob them of the rewards that a lifetime of labor deserves.

It is clear to us that scientific advances and new medical and surgical techniques will account for little if we lack the resources to put our new-found knowledge into practice.

Our college and residency training programs continue to strive toward a solution of the problems that I have outlined. But we cannot do it alone. These are national problems and they require a national effort.

Our association urges the subcommittee to reject the administration's proposals to drastically limit support for health professions education, including the proposed cutback in support for HEAL loan programs.

We also recommend that the following be included in the subcommittee's appropriations bill.

Remote site training. Responding to the special needs of those living in medically underserved areas, Congress, in 1984, authorized the establishment of this training program, and we recommend that it be included in the 1989 appropriations bill.

Primary care. While an estimated 70 percent of the Nation's podiatric physicians have clinical privileges at one or more hospitals, the fact is that as much as 95 percent of all podiatric care is rendered in outpatient settings. The task now facing our colleges and teaching hospitals is to offer the specialized education and training required to practice comprehensive, podiatric primary care.

We urge the bureau of health professions through your legislation to explore the prospects for launching a limited number of demonstration projects designed to support pre- and postdoctoral training projects, as well as traineeships and fellowships.

Geriatric research and research training. Finally, the incidence and prevalence of foot problems among the elderly is extremely high. In order to better prepare doctors of podiatric medicine to care for the burgeoning elderly population, faculty and residents should be afforded access and full participation in geriatric training programs.

We urge the National Institute on Aging to support research targeted on promoting the treatment and prevention of chronic foot problems among the elderly and to train individuals committed to careers in this field.

PREPARED STATEMENT

I thank you, Senator Chiles, for the opportunity to present this statement.

As always, we stand ready to assist you personally, if not the full committee. Thank you again for the opportunity.

[The statement follows:]

STATEMENT OF ANTHONY J. McNEVIN

My name is Anthony McNevin and I am President of the American Association of Colleges of Podiatric Medicine, a nonprofit educational association.

The Association represents the Nation's seven colleges of podiatric medicine, the 232 affiliated public and private teaching hospitals with fourth-year externship and residency training programs, and 3,000 students and 550 residents. It also represents a growing number of continuing education programs approved by the Council on Podiatric Medical Education, with participants in each program ranging from 20 to 300 podiatrists.

Background

As you know, Mr. Chairman, podiatric medicine is that profession which deals with the diagnosis, treatment, and prevention of diseases and disorders affecting the lower extremity.

Since the start of this century, science and technology have combined to help us develop a far better understanding of the foot, how it works, and what can go wrong.

Science has determined, for example, that our feet absorb the impact of up to half a ton of force every day, and that in the average lifetime our feet carry us an average of 100,000 miles. All of this activity is dependent upon one relatively small area that contains one-fourth of all the bones in our body, 19 muscles, and 107 ligaments.

The truth of the matter is that we pay little attention to our feet -- until something goes wrong. That something may be the result of a simple strain or hairline fracture, or it could be the early warning signs of more serious disorders affecting the body, such as heart disease, diabetes, arthritis, and musculoskeletal disorders.

Mr. Chairman, whether the result of a disease, a job-related accident, or a sports injury, all of us -- young and old -- are vulnerable to foot ailments.

We know, for example, that as many as ten percent of all children suffer from congenital foot problems that can curtail their activities and hamper both their physical and emotional development.

At the other end of the spectrum, we recognize that the fastest growing segment of our population -- the elderly -- also happens to be the group most at risk.

For them, in particular, untreated foot problems can mean the difference between leading independent, productive lives or years of limited mobility, pain, and anxiety.

Today, an estimated 95 percent of elderly Americans suffer from foot disorders and, according to the National Center for Health Statistics, one-fourth of all nursing home residents cannot walk as a result of foot problems.

Mr. Chairman, unless there is an adequate supply of podiatrists to meet their needs, many of the elderly will be forced to postpone or forgo treatment altogether -- only to require more extensive and more expensive health care later in life.

For these individuals, foot problems will rob them of the rewards that a lifetime of labor deserves.

It is clear to us that scientific advances and new medical and surgical techniques will count for little if we lack the resources to put our new-found knowledge into practice.

Our colleges recognize that fact and are striving hard to prepare well-trained individuals for the profession. As a result of our efforts, the number of graduates has steadily increased over the past two decades.

In fact, during the period 1976 to 1986 first-year enrollments increased by 45.7 percent -- with minority enrollments showing the most dramatic increase, over 220 percent.

But despite this remarkable growth rate, there are still only 9,700 practicing podiatrists in this country, or about one podiatrist for every 25,000 Americans. And although the number of podiatrists has increased in recent years, the U.S. Public

Health Service still characterizes this as "the profession with the most serious geographic distribution problem."

The problems of supply and distribution affect us all, Mr. Chairman. But the hardest-hit are the elderly and those who reside in underserved urban and rural communities.

Mr. Chairman, problems such as this are perhaps the most threatening breach in our health defenses. For as you know, our health as a Nation can be no better than the knowledge and skills of the health professionals to whom we entrust it.

Our colleges will continue to strive towards a solution to the problems I have outlined. But we cannot do it alone. These are national problems and they require a national effort.

Recommendations

Our Association urges the Subcommittee to reject the Administration's proposals to drastically limit support for health professions training, including the proposed cutback in support for the HEAL loan program. We also recommend that the following be included in the Subcommittee's appropriations bill.

1. Remote Site Training. Responding to the special needs of those living in medically underserved areas, Congress in 1984 authorized the establishment of a Remote Site Training program to (1) recruit and retain students who reside in shortage areas and (2) operate clinical training programs in or near such areas. To date, an estimated 260 individuals have participated in the program.

   Recommendation: Our Association urges the Subcommittee to continue support for this critical program in FY1989.

2. Primary Care. While an estimated 70 percent of the nation's podiatric physicians have clinical privileges at one or more hospitals, the fact is that as much as 95 percent of all podiatric care in the U.S. is rendered outside the hospital setting. Not unlike general medicine, podiatric medicine is challenged with developing attractive training mechanisms that enhance the role of the primary care provider of

podiatric health services. The task now facing our colleges and their teaching hospitals is to offer the specialized education and training required to practice comprehensive, podiatric primary care.

Recommendation: Please urge the Bureau of Health Professions to explore the prospects for launching a limited number of demonstration projects designed to support pre- and post-doctoral training projects, as well as traineeship and fellowships.

3. Geriatric Research and Research Training. The incidence and prevalence of foot problems among the elderly is extremely high. In order to better prepare doctors of podiatric medicine to care for the burgeoning elderly population, faculty and residents should be afforded access and full participation in geriatric training programs.

Recommendation: Please urge the National Institute on Aging to support research targeted on promoting the treatment and prevention of chronic foot problems among the elderly, and to train individuals committed to careers in this field.

Thank you for the opportunity to present this statement, Mr. Chairman. As always, we stand ready to assist the Subcommittee in whatever way we can.

Senator CHILES. Thank you very much.

The way I got to the U.S. Senate was by walking. I started walking at the top end of my State and walked a little over 1,000 miles. I became not only an expert on how to try to keep blisters down, but that was sort of my profession. I had to keep walking. Once I had started, I couldn't quit.

Mr. McNEVIN. Well, universally, it is either a walking process or a running process, as I understand it.

Senator CHILES. I have visited an awful lot of your people along the way.

We are delighted to have you here.

Mr. McNEVIN. Thank you, sir.

STATEMENT OF JUDITH S. MELSON, CNM, DNSc (CANDIDATE), AMERICAN COLLEGE OF NURSE-MIDWIVES

Senator CHILES. Now we will hear from Judith Melson of the American College of Nurse-Midwives.

Ms. MELSON. Mr. Chairman, I am Judith Melson, a member of the American College of Nurse-Midwives and director of the graduate program in nurse-midwifery at Georgetown University.

I appear on behalf of the college's 2,700 certified nurse-midwives. I acknowledge, gratefully, this committee's support of nurse-midwifery and appreciate the opportunity to address the concerns of our profession.

The American College of Nurse-Midwives is the professional organization for certified nurse-midwives in the United States.

Senator CHILES. Would you pull your microphone just a little bit closer, please.

Ms. MELSON. Yes, sir.

Presently, 25 of America's outstanding colleges and universities offer the theoretical and clinical coursework in midwifery that leads to certification as a nurse-midwife.

It is a pleasure to be here today to speak in support of funding to the full level of authorization for title VIII.

The President's 1988 budget request is only $40 million for the education of all health professionals, including certified nurse-midwives. We are hopeful that the overall reauthorization level for 1989 will be the $94 million, as has been proposed in S. 2231.

Federal support of our nurse-midwifery programs is vital to their continuation. Federal funds in the form of program support help indirectly to decrease tuition costs, while the federally sponsored traineeships to students provide an incentive to students to enter these nursing programs.

In addition, the traineeships which are available through the nurse-practitioner and nurse-midwife section of the law have a payback requirement in a health manpower shortage area. In this way, the Federal Government guarantees the availability of some health professionals to provide services to the underserved.

Even without the payback requirement, the Federal funds that have been spent over the past several years on nurse-midwifery education have been repaid many times over by nurse-midwives' services to the poor and underserved in the United States.

Nurse-midwifery practices exist in all 50 States, and a range of services are provided to women regardless of their ability to pay.

The commitment of certified nurse-midwives to providing care to the poor is especially important in light of the effect of the crisis of affordability and accessibility of professional liability insurance on obstetricians-gynecologists and certified nurse-midwives, and its negative impact on access problems for pregnant women.

For example, in some areas of Nevada, patients travel 140 miles for prenatal care; in Alabama, there are 17 counties without obstetrical care.

Over the years, certified nurse-midwives have maintained a superb record of safety and client satisfaction. Nurse-midwifery is also a highly cost-effective approach to health care delivery.

All of us are aware of the acute nursing shortage and of the trend of decreasing enrollments in schools and colleges of nursing. The entire nursing field becomes more attractive as the potential for creative opportunities within nursing become more visible.

The shortage of nurse-midwives is also growing.

For instance, there are 56 unfilled positions in New York and 40 in the State of Florida.

In summary, the American College of Nurse-Midwives urges Congress to fund title VIII of the Public Health Service Act with an appropriation of $94 million in fiscal year 1989.

Continued growth of nurse-midwifery in the United States will help address two serious national health problems—access to maternity and gynecologic services for the poor, and the rising cost of health care.

On behalf of mothers and babies in nurse-midwifery, we thank you for your generous support of nurse-midwifery practice and education, and I acknowledge you for your work in establishing the Commission on Infant Mortality.

[The statement follows:]

STATEMENT OF JUDITH S. MELSON

Mr. Chairman, I am Judith Melson, a member of the American College of Nurse-Midwives and Director of the Graduate Program in Nurse-Midwifery at Georgetown University in Washington, D.C. I appear on behalf of the College's 2,700 certified nurse-midwife members. I acknowledge gratefully this committee's support of nurse-midwifery and appreciate the opportunity to address the concerns of our profession as you consider the appropriation for Title VIII of the Public Health Service Act.

The American College of Nurse-Midwives is the professional organization for certified nurse-midwives in the United States. A certified nurse-midwife is a registered nurse with advanced education in midwifery who cares for women and their infants during the childbearing years. Presently, twenty-five of America's outstanding colleges and universities offer the theoretical and clinical course work in midwifery that leads to certification as a nurse-midwife (listing attached). All of our educational programs have been vigorously assessed prior to accreditation by the College, which is recognized by the Office of Education. In addition, our educational programs comprise three types: certificate programs, masters programs and doctoral programs. It is a pleasure to be here today to speak in support of funding to the full level of the authorization for Title VIII.

President's 1989 Budget Request

The President's 1988 budget request is only $40 million for the education of all health professionals, including certified nurse-midwives. As you know, Title VIII is in the process of being reauthorized. Nurse-midwives are hopeful that the overall reauthorization level for 1989 will be $94 million, as has been proposed in S.2231.

Nurse-Midwifery Educational Programs

Most all students in our twenty-five nurse-midwifery educational programs are nurses who have had several years experience in providing maternity nursing services. These students select the specialty of nurse-midwifery for a variety of reasons. Some select it because it provides an opportunity for more independent decision-making -- within their scope of practice designated by the state laws under which they practice, and defined by the standards of the profession. Others cite their sense of fulfillment and satisfaction in participating in the process of birth. As with other nursing groups, nurse-midwifery is experiencing declining enrollments in schools of nurse-midwifery. The reasons for these declining enrollments are many, including but not limited to:

- the decreasing pool of registered nurses from which nurse-midwifery students are selected;
- the fear of AIDS;
- the cost of professional liability insurance;
- the fear of being sued.

In addition, the nursing shortage crisis has caused some areas of the country to increase salaries for staff nurses in hospital settings as a means of recruitment and retention. Therefore, many nurses who become nurse-midwives are required to accept a decrease in salary. The salary decrease is compounded by the necessity of purchasing professional liability insurance -- the only policy types available being "claims-made" coverage. This type of policy covers only those claims filed during the policy coverage period, regardless of when they occurred. Therefore when a nurse-midwife retires or moves to another state, she or he needs to purchase insurance coverage for claims which will be reported in future years. This coverage is called an extended reporting period or "tail coverage" because it covers the long "tail of risk" from previous years in practice. The cost of the tail is based upon the premium rate paid in the final year of practice and is usually one to one and one half times that premium. As you can see, the tail can be a substantial cost item.

The Role of Federal Funding in Increasing the Numbers of Nurse-Midwife Students.

Federal support of our nurse-midwifery programs is vital to their continuation. Federal funds in the form of program support help indirectly to decrease tuition costs, while the federally-sponsored traineeships to students provide an incentive to students to enter these nursing programs.

In addition, the traineeships which are available through the nurse-practitioner and nurse-midwife section of the law have a "payback" requirement in a health manpower shortage area. In this way the federal government guarantees the availability of some health professionals to provide services to the underserved.

Return on Investment

Even without the payback requirement, the federal funds that have been spent over the past several years on nurse-midwifery education have been repaid many times over by nurse-midwives' services to the poor and underserved in the United States. Today almost half of the care provided by certified nurse-midwives is to poor women and their children. This is a result of both the origins of nurse-midwifery in the United States and the commitment of the profession to improving maternal/child health care in America. Nurse-midwifery had its beginnings in the poor, medically underserved areas of eastern Kentucky in the 1920s. Over the next fifty years nurse-midwives worked extensively with women and families living in poverty. Then, in the early 1970s, more affluent consumers discovered nurse-midwifery. Today, nurse-midwifery practices exist in all 50 states and a range of services are provided to normal, healthy women regardless of their ability to pay.

The commitment of certified nurse-midwives to providing care to the poor is especially important in light of the effect of the crisis of affordability and accessibility of professional liability insurance on obstetrician-gynecologists and certified nurse-midwives and its negative impact on access problems for pregnant women. For example, in some areas of Nevada, patients travel 140 miles for prenatal care; in Alabama, there are 17 counties without obstetrical care.

The problem of access to care is heightened for poor women since we know that many obstetrician-gynecologists refuse to care for Medicaid clients. Much has been written on the reasons for this and many states are in the process of designing incentives to encourage physicians to care for these patients. Certified nurse-midwives, however, continue to serve these clients.

A Safe and Cost-Effective Alternative

Over the years certified nurse-midwives have maintained a superb record of safety and client satisfaction. Nurse-midwifery is also a highly cost-effective approach to health care delivery. Hospital stays tend to be shorter and care regimens less technologically complex (when not medically necessary) with nurse-midwife assisted deliveries.

The Nursing Shortage and Role of Certified Nurse-Midwives

All of us are aware of the acute nursing shortage and of the trend of decreasing enrollments in schools and colleges of nursing. The entire nursing field becomes more attractive as the potential for creative opportunities within nursing become more visible. Nurse-midwifery offers many of the qualities nurses define as important to job satisfaction. There is a variety in work experiences, an opportunity for continuity of care and the establishment of long-term primary care relationships. There is also an opportunity for service -- professional care which contributes to improving the health of America's mothers and babies. Thus, preserving and nurturing the profession of nurse-midwifery enhances the profession of nursing in its entirety.

Summary

- The American College of Nurse-Midwives urges Congress to fund Title VIII of the Public Health Service Act with an appropriation of $94 million in fiscal year 1989.
- Continued growth of nurse-midwifery in the United States will help address two serious national health problems.
  - Access to maternity and gynecologic services for the poor.
  - The rising cost of health care.

Senator CHILES. We thank you, and with regard to your last statement, as chairman of the National Commission on the Prevention of Infant Mortality, I am very cognizant of the important part that midwives play and the great need that we have for trained midwives.

There are a lot of problems with the liability insurance and some of the other things. But the comprehensive network of nurse-midwives operating with physicians for those complicated cases would do much to help some of our problems, especially if we could have some of those same people trained in giving some of the prenatal care at the front end of the service, would help tremendously. We are going to see what we can do to try to promote this.

We thank you for your testimony.

Ms. MELSON. Thank you.

STATEMENT OF DONALD LEGLER, DEAN, COLLEGE OF DENTISTRY, UNIVERSITY OF FLORIDA, GAINESVILLE, FL

Senator CHILES. Now we will hear from Dr. Donald Legler, the dean of the College of Dentistry of the University of Florida.

Dr. LEGLER. Mr. Chairman, I serve as the dean of the College of Dentistry at the University of Florida, and I represent today the American Association of Dental Schools, where I serve on the administrative board of the council of deans of that organization.

I might say that this group uniquely represents all dental educators in the United States including dental schools, a hospital dentistry program, and allied dental programs in auxiliary areas.

I am pleased to make comments today on our views of fiscal year 1989 funding as it might affect dentistry.

The first issue of particular concern to us is general dentistry programs, which really provide for 1 to 2 years of training beyond the dental degree, analogous in some ways to the family practice programs in medicine, targeting newly graduating dentists to perform hospital dentistry, treat AIDS patients, the elderly, the infirm, and increasingly the medically compromised patient.

So we are looking at a different breed of dentist than some of us may have known 30 years ago.

Last year, $2.6 million was appropriated, for which 57 eligible dental schools and over 500 hospitals applied for funding, and only a fraction, really, of eligible applicants could be accommodated.

We would hope that funding might be increased to a level of approximately $10 million in the coming fiscal year.

The second area of interest to us is geriatric training.

There are 143,000 dentists in the United States. Less than 30 have had special targeted training to serve as geriatrician dentists, and to really teach provision of dental care to the elderly population. We are looking toward developing a cadre of such individuals in our schools of dentistry.

Currently, there are funds provided at the level of about $2.7 million per year. We would hope that that might be increased to as much as $14 million, to provide for training of at least 75 geriatric dentists that could be leadership individuals in our dental schools to train not only dental students, but all of those dentists and dental auxiliaries out in the private practice arena for better care of the elderly.

Senator CHILES. How is that going to work?

Dr. LEGLER. How is that going to work?

What we would do would be to identify, in probably affiliated with geriatric education centers, the ability to have a special 2-year structured program or a dental faculty member, young dentists to participate in special training by all of the best folks in such medical centers to look at the whole needs of the elderly persons. They would simply complete the program and, I am sure, be snapped up by dental schools to develop new departments.

Senator CHILES. Do you think that would happen to them? I mean, they would be snapped up. They are not going to go out into their own practice?

In other words, the theory of it sounds great. We are going to train these people and they are going to go out and set up training. But I am just wondering about that.

Dr. LEGLER. Actually, we funded two of those particular kinds of folks at the University of Florida.

Senator CHILES. I guess they would not make that much money for the additional training out in the private sector, would they?

Dr. LEGLER. It would not be the most lucrative kind of opportunity because Medicare and Medicaid are not available to dental patients for the most part.

We are advertising for an individual now at the University of Florida. Quite frankly, we have three applications. There aren't many people out there that have that kind of training.

The only group training such people, frankly, is the VA, and they only have five institutions turning out five people a year.

So, that is important.

Senator CHILES. I think the need is there, especially when you say you need to get your general dentist to know something about telling older people how they should care for themselves.

I am just trying to see whether the plan will work, and how it will work.

Dr. LEGLER. Well, it probably will work. We just need to get it going.

Then, the final comment is simply the AIDS problems affect dental schools as they do everyone else. Our students treat AIDS patients. We have to train them to treat AIDS patients.

We train all of dentists and dental auxiliaries out in society to treat AIDS patients. With the barrier techniques that we now need to implement over the last year or two—gloves, masks, eyewear, robes—we look like the staging crew at Cape Canaveral, now, when we treat a dental patient in our clinic. That is big money to the dental schools—about $200,000 a year. We would hope that a formula-based program to help support dental schools, perhaps allocating a total of somewhere around $11 million, might be made available to help us over this hump.

PREPARED STATEMENT

Thank you for the opportunity of commenting this morning.

[The statement follows:]

STATEMENT OF DONALD LEGLER

I am Dr. Donald Legler, Dean of the College of Dentistry at the University of Florida in Gainesville, Florida. I have served as dean since 1983 and previously was Associate Dean for Research at the University of Minnesota School of Dentistry in Minneapolis, Minnesota. From 1986-87, I was chairman of the General Research Support Review Committee, Division of Research Resources, National Institutes of Health. I am currently a member of the Council of Dental Research of the American Dental Association, and Secretary of the Council of Deans of the American Association of Dental Schools.

I appear today on behalf of the American Association of Dental Schools (AADS), which represents all of the nation's dental schools as well as advanced education institutions, hospital dentistry and allied dental education programs. Ours is the only national organization concerned exclusively with the needs of dental education. We are pleased to present our recommendations for Fiscal Year 1989 funding.

AADS endorses the testimony of the American Association for Dental Research regarding priorities and funding for the National Institute of Dental Research and the National Center for Health Services Research. We also endorse the recommendations of the American Dental Association concerning the National Center for Health Statistics and the Dental Disease Prevention Activity of the Centers for Disease Control. An appropriation of $160 million to the National Institute for Dental Research (NIDR) will allow for a balanced research program in dental science, by supporting regular research grants, research centers, training, and intramural research.

This statement describes our funding recommendations for health professions training programs especially important to dental education.

General Dentistry Residencies and Advanced Education in General Dentistry: Increased support for general dentistry programs is our top priority for the FY 1989 funding cycle. General dentistry programs provide dental graduates with the didactic skills and clinical experience necessary to provide comprehensive care to a wide variety of patients requiring special or complex care, including the elderly, the handicapped, the medically compromised, and those infected with the AIDS virus. The availability of dentists who can serve a broad range of patient needs is especially critical for underserved minority groups and persons in rural areas.

As a result of federal support for general dentistry residency programs over the past ten years, 32 new programs have been created and 230 new positions were funded. General Dentistry grant funds have supported the establishment of 54% of the new non-Federal (non-military or Veterans Administration) programs since 1977, and have been responsible for 60% of the increases in first year general dentistry postdoctoral positions established since the program began ten years ago. Between 1977 and 1987, the percentage of dental school graduates entering general dentistry residencies increased from 15% to 24%. Most of the General Dentistry graduates have remained in primary care, many in underserved areas.

The demand for training, however, has far outpaced the availability of new positions. In 1987, approximately one out of every three applicants for General Dentistry positions was not placed in a program. In FY 1988, 57 dental schools and over 500 hospitals were eligible to apply for only $2.6 million in federal support.

To cover expansion of current programs as well as start-up of new programs, we recommend that the General Dentistry program be funded at $10 million in FY 1989.

Geriatric Education Centers and Geriatric Training

Geriatric Education Centers (GECs), established over the last four years, assist health professions and basic science faculty in coordinating geriatric curricula for health professions students. The Centers enhance the inter-relationships of the professions, and aim to involve all faculty in geriatric medicine.

In FY 1987, GECs received almost $10 million; the AADS recommends that the Geriatric Education Center program funding be increased in FY 1989 to allow for minimal growth in this high priority program.

In 1986, Congress enacted legislation to complement the GEC initiative. This authority, funded for the first time in FY 1988, provides that one- and two-year postdoctoral fellowships be established to train physician and dentist geriatricians. In FY 1988, this Subcommittee's support made $2.7 million available for the initiation of Grants for Faculty Training Projects in Geriatric Medicine and Dentistry. The program is expected to support 15 projects that would begin training approximately 45 medical and dental faculty in July, 1989.

The 1987 U.S. Department of Health and Human Services report to Congress, "Personnel for Health Needs of the Elderly Through Year 2020," pointed out the urgent need to begin training a sufficient "leadership cadre" in geriatric dentisty. Today, of the approximately 143,000 practicing dentists in the United States, fewer than thirty have received formal training at that advanced level in geriatrics. To meet the Department of Health and Human Services goal, approximately 75 dentist trainees must enter programs yearly until after the year 2015. At the current funding level, however, only about 15 dentist-geriatricians will be trained annually. There remains a critical need to increase the number of dental faculty with advanced training in geriatrics. AADS recommends that $14 million be provided for this important initiative in FY 1989.

Acquired Immunodeficiency Syndrome (AIDS)

Testimony presented before the Presidential Commission on the Acquired Human Immunodeficiency Virus epidemic cited the report of a task force on AIDS Health Care Delivery by the Administrator of the Health Resources and Services Administration. Included among the task force's findings are "gaps in the education, training and experience of health care professionals in caring for persons with AIDS," and "gaps in financing to cover the specific health needs of AIDS patients."

Health professions institutions have begun to respond by expanding and enhancing AIDS education and training programs for their students, but there is more that can, and must, be done. Dental education institutions, which lack sources of federal reimbursement available to medicine, seek funding to offset the dramatically increased costs, estimated to be $200,000 per school, associated with teaching dental students to effectively treat and manage patients with infectious diseases. Dental schools have unique needs in this area. Unlike medical schools, which use hospital settings for teaching the clinical aspects of the profession, dental students usually treat patients in the dental school clinic. Changes in infection control procedures necessary to protect all patients, staff, faculty, and students from infectious disease require the upgrading of clinical sterilization equipment and facilities, the purchase of significant quantities of disposable supplies, and the hiring of additional staff. Proper infection control means that each procedure takes more time and utilizes additional supplies. This translates into significantly greater costs.

Our Association recommends that dental education institutions be compensated for this additional cost by applying a formula based on the number of patient visits to the dental education institution's clinic(s) during the year. Such reimbursement will allow dental education institutions to continue to provide care to patients at reduced fee levels while making the costly adjustments necessary to train students to treat all patients in their clinical practices. We recommend an appropriation of $11 million for this initiative in FY 1989.

Dental practitioners can be reached through continuing education programs focusing on AIDS. We believe that these continuing education courses must be federally subsidized if they are to offer training to health care professionals who might not otherwise have access to information about AIDS and infection control. While some continuing education is occurring through the AIDS Education Training Centers (ETC) program, it must be recognized that all dentists throughout the nation need access to accurate, up-to-date information. Reliance on the regional ETCs will leave many of the country's health professionals without access to continuing education; if we wish to reach practicing dentists with continuing education, it must be available locally.

The AADS recommends that support be provided for projects to: train health professions faculty to teach students to provide care and treatment for AIDS patients; implement curricular changes relating to the care of AIDS patients; and provide continuing education on AIDS for health professionals.

Area Health Education Centers (AHECs)

Title VII funding also supports Area Health Education Centers (AHECs), which provide multidisciplinary training to health professions students in non-traditional settings. This program is designed to encourage graduates to locate in rural areas and to establish a bridge between the rural practitioner and the health science centers.

We understand that there is interest in expanding the AHEC program to address the special health problems of those who live in border areas and that oral health screening and treatment could be part of any such initiative. Our Association is most supportive of this approach to the problem of rampant dental decay which remains a major problem among children along the U.S.-Mexico border due to several factors, including poor nutrition, lack of adequate health care counseling, and absence of fluoride. AADS urges the Committee to appropriate $16 million to fund AHECs in FY 1989.

Exceptional Financial Need

The Exceptional Financial Need (EFN) program currently provides funding of educational costs for first-year students with no financial resources. In FY 1987, $6.9 million was awarded to 405 health professions students, an amount which fell far short of the need for this program. Over $21 million would have been required to award funds to all the 1,319 first year health professions students who qualified. S. 2229, reauthorizing Title VII programs, would terminate the Financial Assistance for Disadvantaged Health Professions Students program and broaden eligibility for the Exceptional Financial Need (EFN) program to students in all class years. If enacted, this change will necessitate a substantial increase in the EFN appropriation in order to avoid marked reductions in financial aid to the neediest health professions students. The AADS recommends that the EFN program, if restructured as in S. 2229, be funded at $30 million in FY 1989.

Health Careers Opportunities Program (HCOP)

The Health Careers Opportunity Program is the primary program supported by the federal government to recruit underrepresented minorities into health professions schools, assist them in preparing to enter these schools, and then to retain and graduate them once they are enrolled. Despite some success, significant under-representation still exists. This has created serious problems in the delivery of health care to our nation's Black and Hispanic citizens, which will be exacerbated without continued and increased federal support of the HCOP program.

S. 2229 would authorize $30 million in FY 1989; our association urges the Subcommittee to support an appropriation at this level.

Health Education Assistance Loan (HEAL)

Although the Health Education Assistance Loan (HEAL) program requires no Federal outlay, our Association is very concerned that the program remain a viable "loan of last resort" for dental students. We ask the Subcommittee's assistance again this year in assuring continued access to the HEAL program by inserting language in the FY 1989 appropriations bill that will allow credit guarantees of up to $325 million in HEAL loans for fiscal year 1989.

We thank you for this opportunity to testify on the FY 1989 appropriations and reiterate our appreciation for the substantial efforts members of this subcommittee have undertaken to benefit the health of the American people. AADS would be pleased to respond to any questions you may have.

Senator CHILES. Thank you, sir.

The Peridontal Research Center is still working well?

Dr. LEGLER. It is alive and well and very successful. Thank you.

STATEMENT OF WILLIAM W. HAMILTON, JR., PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.

Senator CHILES. Now we will hear from Mr. William W. Hamilton, Jr., of Planned Parenthood Federation of America, Inc.

Mr. HAMILTON. Thank you, Senator.

We have submitted a comprehensive statement, and I will just speak from notes.

I wanted to start by saying how much we are going to miss you, although I suspect you are not going to miss this process that much. But the leadership that you have shown over these last few years on the Budget Committee and the leadership that you and Senator Weicker have shown in this subcommittee has made a very difficult period for those of us in the health industry a little less difficult, and we are terribly grateful.

Senator CHILES. Hopefully, those years are going to disappear.

Mr. HAMILTON. Well, we would like to think so.

I am appearing on behalf of our president and on behalf of our 181 affiliates in 46 States and D.C. in support of title X of the Public Health Service Act.

Title X is the backbone of the national family planning network throughout the United States. It provides medical and education services targeted to low income women and teenagers, adolescents.

For 7 years now, Congress has resisted, wisely in our judgment, efforts by the administration to fold this program, like so many others we have heard about this morning, into a block grant, and we are reasonably confident that you will resist it again this year.

In your State, the State of Florida, about just under $5 million in title X funds is available, flowing through the State department of health and rehabilitation services. It is used to fund more than 180 county-run public health programs providing family planning services.

In addition, three of our eight planned parenthood affiliates in the State of Florida get some of the money, as do a few nonprofit hospitals.

We are currently awaiting Senate consideration of S. 1366, which is a 4-year reauthorization of the program. I believe you are a cosponsor of it. It came out of the Labor and Human Resources Committee last November, and we hope to have it on the floor in the next few weeks.

That bill authorizes $163 million for family planning services in this fiscal year.

Currently, we are funded at about $136 million. The $163 million was sort of where we begin in the Reagan administration. The last Carter budget had us at about $166 million, I believe.

As Bob Crothers from NFPRHA indicated earlier, we would certainly like to see the trend go back in the other direction, for a change.

Earlier this year, the administration issued some new guidelines governing title X, which would have prevented clinics with providing women with information, counselling, or referrals regarding their options when facing an unintended pregnancy. These regulations in the end were opposed by 36 State governments, including your State of Florida, by 78 national health and other organizations, including every major medical society in the country, by the deans of all 25 schools of public health in the country, and by thousands and thousands of individual citizens.

Your subcommittee last year passed some language trying to thwart that set of regulations, and, unfortunately, the amendment that Senator Weicker offered that you supported was dropped in the conference committee in the face of a veto threat from the White House.

I did want you to know that those regulations have been blocked by Federal courts now in Denver, in New York, and in Boston. Judges, in all three places, including some Republican judges, found them to be both illegal and unconstitutional.

But the administration is going to appeal, anyway.

We think it is time for the administration to stop politicizing the title X program and let us spend our money on serving low income women and not on lawyers. We hope you are right in saying that it is going to change with the elections.

Certainly, Governor Dukakis has been very supportive of family planning in his State, and the old George Bush, when he was in Congress, was one of the original cosponsors of this program. So we have hope.

In summary, we would like to see funding for title X adjusted upward within obviously the restraints that you feel so severely, to insure at least a continuation of the services we are providing and certainly any additional services that can be funded to meet the unmet need.

Second, we would like to see a supplementary fund of $10 million set aside to boost contraceptive product development through the National Institute of Child Health and Human Development.

PREPARED STATEMENT

In this year of focusing on cost-effective programs, we believe support for title X and for contraceptive research should be a high priority for the Congress.

We thank you a lot.

[The statement follows:]

STATEMENT OF WILLIAM W. HAMILTON

INTRODUCTION

I am William W. Hamilton Jr., the director of Planned Parenthood Federation of America's (PPFA) Washington Office. I am appearing on behalf of our president, Faye Wattleton, and the more than 30,000 volunteers and staff who run our 181 affiliates in 46 states and the District of Columbia, the 250,000 individuals who contribute to our organizations, and the more than 4 million women and men who are served by our clinics each year. I want to thank members of the subcommittee for the opportunity to present our views on the need to strengthen the national family planning program and to expand research in contraceptive technology.

As you know, Title X of the Public Health Service Act is at the core of our national family planning clinic network that provides subsidized services to low-income women and teenagers. For the eighth consecutive year, the Administration is seeking Title X's repeal in favor of its inclusion in a block grant to states. Under the Administration's proposal, all federal Title X dollars would simply be turned over to the states, abandoning the national standards for medical care and the national reporting system which have helped to insure the provision of high quality, cost-effective family planning services over the years.

We are confident that Congress will continue its long-standing, bipartisan commitment to family planning this year and retain the Title X program as an important federal categorical program. On November 12, the Labor and Human Resources Committee reported S. 1366, a four year reauthorization of the family planning program. The bill authorizes $163 million for family planning services in fiscal year 1989. S. 1366 also provides separate $10 million authorizations for a new contraceptive development initiative at the National Institutes of Health (NIH) and for an expanded information and education program designed to enable individuals to prevent unintended pregnancies and sexually transmitted diseases. This legislation will soon be considered by the full Senate.

We urge the Congress and this committee to continue your important investment in the Title X program — one federal program where a relatively small increase in spending this year results in tremendous savings in health care and social services costs to the government for many years to come. The important link between family planning and infant mortality was noted by the congressionally-mandated Select Panel for the Promotion of Child Health in 1981 when it reported that, "infant mortality, low birthweight and stillbirths can be reduced through family planning."

Similarly, we urge you to increase support for population research, specifically authorized under Title X and Section 301 of the Public Health Service Act, and to place particular emphasis on applied research leading to the development of new contraceptive technology and on research designed to evaluate the safety and efficacy of existing methods. Recent developments, primarily the withdrawal of the IUD from the American marketplace, make this an urgent matter.

Of 36 million American women (who are seeking to avoid pregnancy), three million are using no contraception, and another three million are using the least effective methods. The most common reason cited for using no method is the fear of possible side effects, despite an increasing body of research demonstrating the safety and efficacy of several major methods. Nonetheless, it is critical that further studies be pursued to identify and counteract the specific risk factors that do exist. At the same time, intensified research in the development of new and improved methods of contraception could greatly enhance our ability as a society to lower the staggering 55 percent incidence of unintended pregnancy that still exists in this country today.

FAMILY PLANNING SERVICES

Mr. Chairman, the Title X program prevents unintended pregnancies, reduces the need for abortion, and provides basic health services to a large group of medically underserved women. Moreover, in addition to providing basic contraceptive services (including natural family planning) and infertility diagnosis, Title X-supported clinics also offer health screening assessments and either simple treatments or referral for anemia, hypertension, cervical and breast cancer, sexually transmitted diseases, kidney dysfunction and diabetes. Even the Reagan Administration has called family planning "a vital health care program for women in this country." Clinics such as those financed through Title X often are the first place low-income women - and especially teenagers - receive formal medical care. U.S. Surgeon General Koop and other public health officials have recommended that family planning clinics help provide AIDS testing and counseling services, in addition to their existing services. Further federal investment in the Title X program is wise and prudent, particularly at a time when the existing network of family planning clinics may be called upon to assist in halting the deadly AIDS epidemic.

Yet, despite the accomplishments of the Title X program, a tremendous number of women continue to go unserved. In the United States today, there are approximately 9.5 million low-income women and five million teenagers at risk of unintended pregnancy (that is, sexually active, fertile and not seeking to become pregnant). In 1983, the last year for which data are available, the organized clinic system made family planning services available to 5 million women, 1.6 million of whom were teenagers and 80 percent of whom were low-income, i.e., below 150 percent of the poverty line. Title X continues to be the single largest source of funds for this network, comprising 34 percent of the total federal and state expenditures. Primarily through the help of Medicaid or other third-party arrangements, an additional 3.2 million women were able to obtain contraceptive services from private physicians. The rest did not receive services.

Unfortunately, the growing need for contraceptive and basic reproductive health services provided by Title X is colliding with a shrinking federal commitment of funds. In FY 1981, Title X was funded at $166 million. The effects of the 25 percent cut later that year and in FY 1982 were severe. Straining to avoid turning patients away, clinics around the country reduced the scope of their services, especially community outreach to "hard to serve" patients. They have found it difficult to maintain, much less expand, educational programs geared toward adolescents and their parents — exactly the sorts of programs Congress has said it wants from Title X. A $16 million increase in FY 1984 and an additional $2.5 million for FY 1985 brought Title X funding from $124 million in FY 1982 to $142.5 million in FY 1985. Funding remained frozen at that level for the next two years while the transfer of administrative expenses from a general PHS account to the Title X account resulted in a $6 million dollar cut in services. In FY 88, only $136 million is available for family planning services under Title X.

RESEARCH

Title X currently authorizes biomedical research in the reproductive sciences, social and behavioral studies, contraceptive development and contraceptive evaluation. The National Institute of Child Health and Human Development (NICHD) administers all these areas of research, which together are presently funded at approximately $109 million, only a tiny fraction of the total NIH budget. Perhaps part of the reason this area of study receives such a low priority at the National Institutes of Health (NIH) is that NIH is primarily disease-oriented, whereas research of this type mainly benefits healthy people. The irony, of course, is that the strides we are able to make as a society in this field directly touch the lives of virtually all Americans, not to mention the rest of the world, for which NIH is a major source of research in contraceptive technology and development. Similarly, much of what we know today about the tremendous health, social and economic costs of adolescent pregnancy - to the adolescents and their families as well as society as a whole - has been generated by work in the social and behavioral research component. It is extremely important that greater financial support be given to research in human reproduction and population.

We are especially concerned, however, about contraceptive research. Less than 10 percent of the current funding spent on population research goes for applied research toward the development of new contraceptive methods and toward evaluating the safety and effectiveness of existing methods.

Five years ago, the Office of Technology Assessment (OTA) recommended that an additional $20 million annually be provided in federal funding for contraceptive technology, noting that available research opportunities are only waiting to be exploited. This is not a field for which a single, even a massive, injection of funds would be adequate. Rather, steady and reliable funding at a modestly higher amount could bring some of these leads to fruition.

As you have heard from Administration testimony, NICHD continues to state that its 1985 Contraceptive Development Initiative is a priority. However, prior funding commitments may make that initiative less a reality than planned. Mr. Chairman, we need new methods of contraception. And we need to reassure ourselves about the safety and efficacy of current ones. We applaud NICHD's efforts in this area. At the same time, we strongly urge you to endorse a specific increase for applied research in contraceptive development and evaluation, through an earmark or committee report directives.

SUMMARY AND RECOMMENDATIONS

In conclusion, Mr. Chairman, Planned Parenthood makes the following recommendations to the subcommittee:

First, that funding for Title X be continued at a level adjusted to insure a continuation of the vital services now provided, as well as an expansion of services to the millions of women and teenagers in need of services who currently are not being served.

And secondly, we recommend that a special ~~supplementary~~ fund of $10 million be provided specifically to boost the contraceptive development initiative already outlined by NICHD.

In this year of focusing on cost-effective programs, we believe that continued support for Title X and for contraceptive research should be high priorities.

Thank you.

Senator CHILES. We thank you very much for your testimony.

It sounds like we can list still a few of the people as doubtful as to whether we should have the new regulations or not.

STATEMENT OF L. THOMPSON BOWLES, M.D., PH.D., DEAN FOR ACADEMIC AFFAIRS, GEORGE WASHINGTON UNIVERSITY, SCHOOL OF MEDICINE AND HEALTH SCIENCES, FOR THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Senator CHILES. Now we will hear from Dr. Thompson Bowles, the dean of academic affairs at George Washington University, for the Association of American Medical Colleges.

Dr. BOWLES. Good morning, sir.

My name is Tom Bowles, and I am the dean for academic affairs at the George Washington University School of Medicine and Health Sciences.

The Association of American Medical Colleges, for whom I speak this morning, appreciates this opportunity to state its views on the fiscal year 1989 appropriations for the Department of Health and Human Services.

We have submitted a more detailed statement for the subcommittee's review, and I will make my remarks brief this morning.

The AAMC would like to commend you and Senator Weicker and members of this subcommittee for continued support of health research and education. Your commitment has contributed greatly to this Nation's quest to improve the health and well-being of all Americans.

Our message is straight-forward: continued Federal investment in the research and education is a wise and vital investment in our country's future.

The AAMC fully supports the recommendations of the Ad Hoc Group for Medical Research Funding of $8.471 billion for the NIH and $716 million for research and research training at ADAMHA.

This proposal would permit award rates for competing research project grants of 41 percent for NIH and 35 percent for ADAMHA.

In addition, research requires a complex system of support, beyond the direct costs of the research. The ad hoc group proposal provides for a balanced expansion of other essential programs, including research training, general clinical research centers, and biomedical research support programs.

We also ask that Congress address the pressing need for renovation and replacement of facilities for biomedical and behavioral research. It is clear that far more than the $250 million requested by the ad hoc group is necessary to resolve this growing problem, that will be even more difficult to redress in the future if action is not taken now.

The AAMC believes that access to medical education should in no way be determined by financial status or ability to pay. Programs targeted to financially disadvantaged and minority students should be funded as generously as possible, so that the prospects of a sizable debt following graduation will not deter these students from pursuing careers in medicine.

The President's fiscal year 1989 budget eliminates funding for exceptional financial need scholarships and the financial assistance for the disadvantaged program.

The President also proposes to replace the categorical training programs of title VII and title VIII of the Public Health Service Act with a $40 million consolidated matching grant program. A majority of these programs received less money in fiscal year 1988 than in fiscal year 1987. We would respectfully urge the subcommittee to provide funding at least at the fiscal year 1987 level for these programs that address critical national needs.

PREPARED STATEMENT

I regret that time constraints limit the opportunity to address other important health programs under the subcommittee's jurisdiction.

The AAMC again thanks you for your valued support in all of these programs.

[The statement follows:]

STATEMENT OF L. THOMPSON BOWLES

The Association of American Medical Colleges (AAMC) appreciates this opportunity to state its views on the FY 1989 appropriations for the Department of Health and Human Services (DHHS). The Association represents all 127 U.S. accredited medical schools and their students, 435 major teaching hospitals, and 85 academic and professional societies, whose individual members are engaged in medical education, biomedical and behavioral research, and patient care.

The Association commends this Subcommittee for its dedication to the research and education programs under its purview. This continued commitment has contributed greatly to improving the health and well-being of all Americans, and the members of this Subcommittee can take justifiable pride in what they have helped to accomplish.

Our message is straightforward: continued investment in research and education is a wise and vital investment in our country's future. In addition, this nation's poor should have access to quality health care regardless of their ability to pay.

We understand the implications if the budget deficit is not brought under control. And we appreciate the difficult choices that Congress must make for the coming fiscal year. Yet the ravages of disease and disability are not lessened by the current fiscal situation. Disease and disability continue to exact a terrible toll from our society, in terms of both the billions of dollars in direct care and indirect medical costs and the incalcuable cost in pain and suffering and premature death.

This nation can and must meet the challenges posed by: the 3 million Americans afflicted with Alzheimer's disease; the 1 out of 3 babies destined to develop some form of cancer during their lifetimes; the 66 million Americans with cardiovascular disease; the 1.5 million carriers of the Human Immunodeficiency Virus (HIV); the 30 million who suffer from mental illness; the 25 million who abuse alcohol or other drugs; and the countless others with or destined to become afflicted with diseases too numerous to mention.

The Association firmly believes that the principal hope for ameliorating these conditions is a steady investment in research. The Federal government has a unique and vital role in the nation's biomedical and behavioral research effort through its support of the National Institutes of Health (NIH) and the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). Continued investment in the research conducted and supported by these agencies not only provides the foundation of scientific knowledge upon which potential preventive, diagnostic and therapeutic advances are built, but also has a beneficial impact on many sectors of the economy and enhances our competitiveness with foreign countries.

The AAMC fully supports the the Ad Hoc Group for Medical Research Funding FY 1989 recommendations of $8.471 billion for NIH and $716 million for the research and research training programs within ADAMHA. These recommendations would provide for a balanced expansion of all programs at these agencies and would permit award rates for competing research project grants of 41 percent for NIH and 35 percent for ADAMHA. The Ad Hoc Group agrees with the consensus within the scientific community that an award rate of 50 percent is appropriate on the basis of the quality of the research applications.

In addition, research requires a complex system of support beyond the direct costs of the research. Federal support for biomedical and behavioral research must be broadened and redefined to include the research infrastructure. The Ad Hoc Group proposal includes support for approximately 12,750 trainees at the NIH and ADAMHA, and would provide funds for increasing tuition costs, stipends, and other training costs.

We also ask that Congress address the pressing need for renovation and replacement of facilities for biomedical and behavioral research. In FY 1988, Congress provided nearly $24 million to repair, renovate, modernize, and expand existing extramural facilities and purchase equipment for AIDS research. It is clear that far more than the $250 million requested by the Ad Hoc Group is necessary to meet actual need in this area. However, this request has been made to draw attention to a growing problem that will be even more difficult to redress in the future if action is not undertaken now.

Two NIH programs deserve special emphasis. General Clinical Research Centers (GCRC) provide essential resources for extramural clinical research, which serves as the crucial bridge between the laboratory and the patient. The program currently supports 78 GCRCs. Important areas of ongoing research include acquired immune deficiency syndrome (AIDS), cancer, diabetes, genetic disorders, arthritis, and aging.

The Biomedical Research Support Grant (BRSG) program allows institutions to meet emerging opportunities rapidly and efficiently by supporting pilot research projects, recruiting scientists, promoting career development, and purchasing shared resources. The AAMC believes that the BRSG program should receive at least $74.5 million in FY 1989.

With regard to student financial assistance, the AAMC continues to believe that, to the extent possible, medical students should pay for their own education, whether through family and individual resources or through borrowing. However, this does not mean that access to medical education should in any way be determined by financial status and ability to pay.

During the 1980s there has been a significant shift in the source of medical students' financing. In 1980-81, 34 percent of total medical student financial assistance was in the form of scholarships; by 1985-86, this had dropped to 24 percent. Reliance on the market-rate Health Education Assistance Loan (HEAL) program has continued to expand. For the schools reporting, HEAL borrowing increased 13.5 percent in 1985-86. The HEAL program accounted for 20.2 percent of all medical student aid in 1985-86, compared with 3.8 percent in 1980-81. As a result, student debt loads have increased, both in terms of numbers of students involved and the size of their debts. In 1987, 82 percent of our medical graduates borrowed an average of $35,621 to finance their education.

In view of these trends, it is vital that those programs targeted to financially disadvantaged and minority students be funded as generously as possible, so that the prospects of a sizable debt following graduation will not deter them from pursuing careers in medicine. We are particularly concerned in view of the administration's continuation of its attempts to eliminate these programs. As the Subcommittee is well aware, the president's FY 1989 budget eliminates funding for two vitally important student financial assistance programs: the Exceptional Financial Need scholarships and the Financial Assistance for the Disadvantaged program.

In addition, the president proposes to replace the existing categorical training programs in Title VII and Title VIII of the Public Health Service Act with a $40 million consolidated matching grant program. This proposal would provide $172 million less than these programs received in FY 1988. The administration continues to insist that these programs increase the number of health professionals. Quite to the contrary, these funds are necessary to train health professionals to address crucial areas of national need, such as geriatrics, preventive medicine, and primary care. In addition, they facilitate the participation of underrepresented minorities and disadvantaged students in medicine. A majority of the Title VII and Title VIII programs received less funding in FY 1988 than in FY 1987; thus, we respectfully urge the Subcommittee to assure that funding be provided at least at the FY 1987 level for these programs that address critical national needs.

The hospitals represented by the AAMC assume a major responsibility for providing care to Medicaid patients and those individuals who are unable to pay for hospital and physician services. At a time when 37 million Americans have no health insurance, and millions more are under insured, the AAMC believes that any reduction in Medicaid funding would be the equivalent of our nation turning its back on its poor and disadvantaged. Therefore, we support full funding of Medicaid and other low income health programs.

The Association regrets that time constraints limit the opportunity to endorse other important health programs under the Subcommittee's jurisdiction that should be continued at reasonable levels. These include such activities as the National Center for Health Services Research and Health Care Technology Assessment, the National Center for Health Statistics, and the National Institute for Occupational Safety and Health, as well as the Department of Education's National Institute for Handicapped Research.

Senator **Chiles**. We thank you, and we thank you for your testimony.

Doctor, one of our problems is that we were cut pretty drastically in the funding request of the Appropriations Committee; we were cut from what the Budget Committee resolution had provided, which I think was barely adequate, but it was, perhaps, adequate.

We sought assistance from your group and every other group that we could try to get in trying to see that the Appropriations Committee would give us adequate funding. But we didn't get it. So we are hurting.

Dr. **Bowles**. We understand and respect the constraints that you face and appreciate your attempts.

Senator **Chiles**. All right, sir.

STATEMENT OF MICHAEL K. GEMMELL, EXECUTIVE DIRECTOR, ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

Senator **Chiles**. Now we will hear from Michael Gemmell, the executive director of the Association of Schools of Public Health.

Mr. **Gemmell**. Thank you very much for the opportunity.

I am Mike Gemmell of the Association of Schools of Public Health. I am appearing on behalf of the 24 deans of schools of public health that are located in 18 States and in Puerto Rico.

For more than three decades, the Federal share of graduate training for public health leaders has consisted of partial reimbursement from the Federal Government for the training costs incurred by the schools of public health.

Business schools prepare students primarily for business, law schools primarily for law, and medical schools primarily for the diagnosis and treatment of individual patients. Only in schools of public health are physicians, dentists, nurses, engineers, economists, lawyers, planners, physical, and social scientists brought together to prepare for roles in which the improvement in the quality of life of the citizenry as a whole is a primary objective.

Over the years in which the Federal funds have met a portion of the training costs in schools of public health, there have been suggestions that the schools should be supported by States and the private sector. But the private sector regards training for public service as a public responsibility. They know that the majority of our graduates go into the public and voluntary sector.

Over 80 percent of our graduates go into the public and nonprofit sectors.

States in which private universities' schools of public health are located regard the production of health manpower as a national, rather than a State responsibility. There are national schools with students coming from all States and graduates serving all of the States. In fact, when they were first created back in 1958, "West Points of health" is what they were called.

Similarly, the schools in State universities cannot expect full State subsidization of training. State legislatures are well aware that only 25 percent of the students come from or will be working in the States in which they are trained. Furthermore, as employees of Government, universities, and private, nonprofit health agencies, public health graduates receive modest salaries, in contrast to the high remuneration received by most health professionals.

Federal support is also justified in the fact that there are shortages of public health specialists. According to HHS, there are shortages of epidemiologists, biostatisticians, and environmental health specialists, nurses and health educators needed to address the problems of the young, the elderly, the disadvantaged, et cetera.

Finally, we ask support for the expansion of the CDC program on prevention research. Only 3 out of 13 centers are currently funded by CDC. They are conducting research on ways to promote good health and prevent disease. Each center works closely with local health agencies, as well as with providers of health services to develop new ways of promoting health and improved methods of appraising health hazards and risk factors.

In short, Mr. Chairman, they are developing state-of-the-art prevention techniques.

There is a need for three additional centers. There are currently 12 approved, yet unfunded, and they all meet strict peer review criteria.

PREPARED STATEMENT

Thank you very much for allowing us the chance to present our views. We have submitted a full statement for the record. The specific details of our request are outlined on page 8 of our testimony.

Thank you, Senator.

Senator CHILES. Thank you very much for your appearance here.

[The statement follows:]

STATEMENT OF MICHAEL K. GEMMELL

Mr. Chairman and members of the subcommittee, I am Mike Gemmell, Executive Director of the Association of Schools of Public Health.* The deans from the 24 Schools of Public Health appreciate the opportunity to present their views on future funding of academic public health programs.

Every study and report, dating back to 1979, has warned of the shortages of public health professionals.

These bleak future assessments, from government studies to academic experts, continue despite a 45% increase in graduates from the 24 U.S. graduate Schools of Public Health between 1974 and 1988.

Indeed, the heightened demand for graduate education in public health and contracted government budgets, points to a deterioration in the quality of instruction or to cuts in enrollment. Perhaps both.

The Department of Health and Human Services, in assessing the status of health personnel, recently declared: "The size, numerical adequacy, training, and competency of the public health work force are matters of direct public concern."*

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* ASPH is the only national organization representing the Deans, over 1,800 faculty and the 9,500 students of the 24 Schools of Public Health. The Schools represent the primary education system that trains personnel needed to operate our nation's public health, disease prevention and health promotion programs. ASPH's principal purpose is to promote and improve the education and training of professional public health personnel. It was formed in 1959 in response to the need to give a national voice to academic public health. See Attachment A for a list of the 24 U.S. Schools of Public Health.

In that report, HHS asserted that "the Federal government's responsibilities and objectives in the field of health promotion and disease prevention warrant a continued high level of concern for manpower resources in public health. Adequately trained public health professionals, effectively utilized, are essential to progress in prevention of disease, identification and control of environmental health goals."

The areas cited by HHS with shortages of specialists were clear:

- Epidemiologists need to deal with non-infectious diseases and new generation infectious diseases like AIDS

- Biostatisticians

- Environmental health professionals, skilled in toxicology and to assess the risks from hazardous chemical and physical agents rampant in our environment

- Public health nurses, nutritionists and health educators to deal with the health problems of children, the aged and disadvantaged

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* "Fifth Report to the President and Congress on the Status of Health Personnel in the United States" (1986) by the U.S. Department of Health and Human Services (HHS). For a summary of the report, see Attachment C.

Furthermore, a HHS advisory panel, the Graduate Medical Education National Advisory Commission, projected a shortage of some 1,500 less than the 3,550 public health and preventive medicine physicians needed in the 1990's.

These grim forecasts come at a time when the public health student population is changing and the graduate faculties are aging.

Between 1977 and 1988 enrollments shot up about 36% to over 9,500. The faculty, however, over the same period grew only from 1,166 in 20 accredited schools to 1,800 in 24 schools.

Equally distressing is the decline of physicians -- down to 17.6% in 1985 -- in academic public health. Of the 24 schools, 17 have two or fewer physicians at the entry level rank of assistant professor. In critical supply are physician educators trained in preventive medicine, epidemiology, biostatistics and toxicology.

At the same time many health science students are shunning careers in public health because of the wrenching 60% cut by Congress in traineeships since 1981 and the high costs of taking out HEAL loans. The field is not attracting an adequate number of physicians, engineers, nurses, chemists and physical scientists. The trickle of engineers that entered public health through the mid-1970s has all but dried up.

State health officers are particularly alarmed about the low number of nurses trained at the graduate level in public health.

The "West Point of Health" is what President Eisenhower dubbed the schools in 1958, when he signed legislation recognizing the education of public health leaders as a Federal responsibility to be shared with the schools. Indeed, it was pointed out at the time that if the schools of public health had not existed, the public health equivalent of a military academy would have had to be created.

For nearly 30 years a Federal responsibility has been recognized in a partial reimbursement (e.g., capitation and student traineeships) of the cost of educating these public health leaders. The majority (80 percent) of these graduates work in the public or non-profit sector, where salaries are modest by any measure. In 1982, a survey by the Association of Schools of Public Health, found that the median income of graduates was only $21,600. By 1986 the median income was only $28,000 (see attachment B) for these highly qualified and vital public service professionals, hardly competitive with the private sector.

Consequently, the ASPH is incredulous that the Administration would recommend the end to Federal support for public health graduate education as it has over the past decade. Given the current federal budget deficit, certain reductions in spending are justified. But to terminate programs that promote health and prevent disease (e.g., public health training), only adds to that deficit. It's a commonly held belief that prevention saves both lives and money.

The vitality of a nation can be measured in part by the health of its people.

The work of public health has provided some dramatic results in recent years. Polio, the childhood scourge of the 1950s, has been nearly eliminated. The worldwide eradication of smallpox is another example of public health practice at work. Death rates from heart attacks and strokes have been reduced by more than 1/3 since 1970. Environmental and occupational hazards have been identified and reduced.

Adult Americans, for the first time in history, are gaining about two years of life per decade. Children born in 1984 have an average life expectancy at birth of 74.7 years, a gain of nearly three years since 1974. Yet the AIDS threatens to block further advances in health status. We don't have adequately trained health professionals to deal with this threat.

Congress enacted Superfund to clean-up the environment. Yet there is a shortage of trained technical people needed for site clean-up and hazardous waste management.

This shortage is only symptomatic of shortages in the public health field that have been perceived or documented in a litany of reports.

While these problems are being dealt with by the public health system, it is a system under strain.

Faculty shortages first pointed to by the U.S. Surgeon General in 1979 still loom large, especially in occupational and environmental health, epidemiology, biostatistics, nutrition and geriatrics.

Enrollments in the Schools of Public Health have increased, but the number of physicians choosing academic public health as a career has not kept up to traditional standards.

The increased interest in graduate education has also increased the student-to-faculty ratio, risking a deterioration of the quality of education or cuts in enrollment, or both.

Public health is a national responsibility. Schools of Public Health train personnel for public service. The Federal government has a direct interest in assuring that an adequate supply of public health personnel is trained in quality institutions to manage and operate the health delivery system in the national interest.

The ASPH believes that continued Federal assistance is actually an investment at the front end of the health care system. The schools, through their educational efforts, not only will help prevent illness, but also will help slow down the rapidly escalating costs of medical care.

The Administration has recommended that the authorities for providing assistance to Schools of Public Health be terminated. The rationale for this recommendation is that state resources are available to the schools and that student assistance is available through other sources.

However, this is not the case. Stable support for Schools of Public Health, other than legislative support under the Public Health Service Act, is simply not available.

It does not make sense for the Federal government to foster programs that will require substantial numbers of public health professionals without insuring that financial resources are available to provide for the competent training of such personnel.

Thank you for giving us the opportunity to testify today. Outlined below, Mr. Chairman, are our FY89 appropriations requests to adequately fund HRSA and CDC academic public health programs of primary concern to the 24 U.S. Schools of Public Health:

APPROPRIATIONS (Millions)

	Final FY 1986	Final FY 1987	Final FY 1988	Pres. FY1989 Requests	ASPH Requests FY 1989
Institutional Support* (Capitation)	$5.0	$5.0	$4.7	0	$5.0
Traineeships*	$3.0	$3.0	$2.8	0	$5.0
Preventive Medicine Residencies*	$1.6	$1.6	$1.5	0	$3.0
Special Projects* (curriculum development)	--	--	--	0	$5.0
Centers for Health Promotion and Disease Prevention (CDC)**	$1.5	$1.5	$1.5	$2.0	$5.0

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* Authorized under Title VII of the Public Health Service Act. P.L. 99-129 expires September 30, 1988. Amounts requested reflect ASPH reauthorization recommendations.

** P.L. 98-551 expired on September 30, 1987. There is a reasonable expectation that the program will be reauthorized this year. P.L. 98-551 authorized the establishment of thirteen prevention centers. Only three have been funded. The $5 million requested in FY89 would continue the present three and provide start-up funds for three to five more.

ATTACHMENT A
ACCREDITED SCHOOLS OF PUBLIC HEALTH

University of Alabama at Birmingham
Boston University
University of California, Berkeley
University of California, Los Angeles
Columbia University
Harvard University
University of Hawaii
University of Illinois at Chicago
Johns Hopkins University
Loma Linda University
University of Massachusetts
University of Michigan
University of Minnesota
University of North Carolina
University of Oklahoma
University of Pittsburgh
University of Puerto Rico
San Diego State University
University of South Carolina
University of South Florida
University of Texas
Tulane University
University of Washington
Yale University
State University of New York at Albany
(will seek accreditation in 1990)

ATTACHMENT B

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

HIGHLIGHTS OF THE DATA ON 1986 GRADUATES

Surveyed in February 1987

Employment

82.1%	of the graduates are employed
11.5%	of the graduates are continuing their education
5.0%	of the graduates are unemployed and seeking employment

Type of Employing Organization

47.1%	of employed graduates work for tax-supported organizations such as federal, state, regional or local government (including state supported higher educational institutions)
32.8%	of employed graduates work for voluntary (non-profit) organizations
18.9%	of employed graduates work for proprietary (for-profit) organizations

Types of Services Which Graduates are Providing

35.8%	of graduates are providing administrative, planning or evaluation services
18.6%	of graduates are providing clinical, laboratory, or social services
14.6%	of graduates are providing education or research services to students
7.3%	of graduates are providing public health community organizational services
11.0%	of graduates are providing consultation services

Earning Levels of Employed Graduates

50%	of employed graduates earn less than $28,000 per year

Financial Assistance During Training

25.8%	of graduates depended on traineeships, scholarships, fellowships or grants as the primary source of funds for meeting educational expenses
22.2%	of graduates depended on employment earnings as the primary source
21.5%	of graduates depended on loans as the primary source

Education Related Indebtedness

60%	of graduates reported some amount of education-related indebtedness. The median indebtedness for these graduates was $10,000. In addition, 41% reported that they already had education-related indebtedness when they entered their school of public health.

ATTACHMENT C

Excerpts from the DHHS

FIFTH REPORT TO THE PRESIDENT AND CONGRESS ON THE STATUS OF HEALTH PERSONNEL IN THE UNITED STATES (1986)

Public Health Shortages (in general)

Although supply and requirements for public health personnel cannot be discussed with the same precision as other health professions, existing studies and prevailing professional judgments point to several occupations with personnel shortages and other occupations in which qualified personnel are difficult to recruit. There are perceived shortages of epidemiologists, environmental health professions including toxicologists, biostatisticians, nutritionists, public health nurses, and physicians trained in public health and preventive medicine. Studies are under development to verify these perceived shortages (page 11-9).

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Specific Shortages

DHHS workshops in 1981 and 1982 (DHHS, 1982) and follow-up reports in 1983 and 1985 (Magee, 1983; Brown, 1985; Greenberg and Magee, 1985) confirmed these findings and suggested the following areas need increased production of highly trained public health specialists:

- Epidemiologists who can deal with noninfectious disease and trauma, particularly those of environmental and behavioral origins
- Environmental health professionals trained in toxicology and assessment of the risks associated with hazardous chemical and physical substances
- Biostatisticians competent in the design and implementation of highly controlled studies
- Nutritionists trained in public health, especially at the doctorate level, who can function as researchers and faculty members
- Health administrators educated to address changing cost containment and reimbursement issues
- Nurses with a public/community health orientation, who can identify high-risk groups, work with community organizations in prevention programs, and deal with the special needs of the elderly, chronically ill and disadvantaged
- Physicians trained in public health and preventive medicine

It is recommended that the schools need to pay closer attention to the types of students they seek. The recruitment of physicians, other health professionals, scientists, and engineers in related disciplines -- that is, individuals with backgrounds best suited to contribute to public health work -- is lagging (page 11-18).

Public Health Physician Shortages

The shortage of physicians and certain scientists (e.g., nutritionists and toxicologists) opting for advanced public health training is a major issue. Their scientific and technical backgrounds, when coupled with graduate preparation in the public health sciences, uniquely qualified them for leadership in practice, research, and faculty roles identified as being in short supply.

Shortages of physicians in public health are likely to continue. The number of physicians who regard themselves as primarily working in preventive medicine has declined steadily in recent years (page 11-18).

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Training Current Worker Needs

In 1980 it was estimated that of a primary public health work force of approximately 250,000 individuals, about 25 percent had graduate training in public health. Estimates for 1985 suggest that approximately 75,000 personnel or about 30 percent have such training. Although precise data are not available, experts contend that large proportions of the environmental health, public health nursing, nutrition, and health education personnel currently in the work force have not received formal basic preparation in public health principles, theory, and methods...It is recommended that increased emphasis be given to professional development programs for practicing public health professionals (page 11-19).

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Shortages of Faculty

The Bureau of Health Professions' 1981-82 workshop series on public health personnel (DHHS, 1982) identified a shortage of qualified faculty and researchers with expertise in a number of high-priority subject areas. Faculty and researchers in chronic disease and environmental epidemiology, toxicology, and risk assessment of chemical and physical agents in the environment are reported to be in high demand and low supply. Difficulties in recruiting physicians for faculty positions in public health are also reported. A second group expected to be in short supply in university faculties includes nutritionists, occupational health specialists (nurses, industrial hygienists), and analytical scientists (mathematical statisticians, biostatisticians, and computer specialists). In each of these groups, competition between universities and private industry is expected to be keen, particularly for those with extensive training and experience. Salary differentials between universities and industry suggest that the recruitment problems of academic and research institutions will continue. It is therefore recommended that approaches be developed to address the recruitment and retention gap of highly skilled faculty and researchers (page 11-20).

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Curriculum Development Needs

In September 1984 a series of five workshops was conducted by the Bureau of Health Professions to develop recommendations for training health professionals to be more effective in health promotion and disease prevention activities...The recommendations addressed the following areas: increasing the effectiveness of faculty in teaching preventive concepts; developing curricula to allow more meaningful material in didactic and experiential education; selecting students who demonstrate positive attitudes and behavior toward health promotion and disease prevention; including these concepts in accreditation standards and certification and licensure examinations; expanding research in this area; and developing closer links between industry and the health profession education community. The recommendations represent a comprehensive strategy for health profession educators to address health promotion and disease prevention concepts through the educational process. It is recommended that the strategy of incorporating health promotion and disease prevention concepts in the education of health professions (as proposed by five workshops in 1983) be implemented (page 11-21).

STATEMENT OF CHARLES R. MODICA, J.D., CHANCELLOR, ST. GEORGE'S UNIVERSITY SCHOOL OF MEDICINE, GRENADA, WEST INDIES

Senator CHILES. Now we will hear from Chancellor Charles Modica of the St. George's University School of Medicine.

Mr. MODICA. Thank you, Mr. Chairman.

I am very pleased to appear before you today to discuss student financial assistance and issues related to health professions. This will be an abbreviated statement.

Senator CHILES. Your full statement will be included in the record.

Mr. MODICA. Thank you.

The President's budget proposal for fiscal year 1989 for student aid programs is vastly improved over past years. The demand and genuine need for Federal resources for students seeking educational assistance continues to be significant.

We are encouraged that additional resources have been recommended for guaranteed student loans. This program is one of the only Federal student aid programs in which U.S. students attending foreign medical schools are able to participate.

Since St. George's was founded in August 1976, nearly 1,100 students have graduated with degrees in medicine, many of whom return to the United States to practice medicine in underserved areas. Often in inner city area teaching hospitals that treat great numbers of low income and indigent patient populations, 80 to 90 percent of residency positions are filled by graduates of foreign medical schools. There would be a significant problem in handling the patient load in many of these hospitals if not for residency slots being filled by eager graduates from non-U.S. schools, such as St. George's.

The journal of the American Medical Association, in its January 18, 1985, issue, reported that St. George's University School of Medicine had the highest initial pass rate of all the leading foreign medical schools in the world.

Senator CHILES. What's your pass rate now?

Mr. MODICA. That particular exam, the ECFMG, is not given any more. They have what they call the FMGMES, and they don't publish, unfortunately, the pass rates of any of the schools in the FMGMES. In fact, that is why we cite the ECFMG statistic. It is the last published statistic on foreign medical schools.

In that exam, we had an 84-percent pass rate, which was the highest of all leading foreign medical schools.

As each class at St. George's finishes its second year of medical education, approximately one-third of that class transfers to U.S. medical schools to complete their education. This is also one of the highest rates in the world.

In 1986, Congress established the Council on Graduate Medical Education, COGME, an advisory body comprised of a representative sample of experts in medical education. The Council on Graduate Medical Education was asked to issue a report to the Secretary of HHS and the Congress to advise them on how they should deal with issues related to graduate medical education from the standpoint of public policy.

This is the first time in almost a decade since the GMENAC committee that the issue of graduate medical education has been studied thoroughly and extensively by a nonbiased field of experts.

The conclusions and recommendations of the council are now being prepared for release to Congress in July. The COGME Subcommittee on Foreign Medical Graduates conclusions and recommendations include that if the Government has no rational basis for denying public funds for graduates of foreign medical schools and students of foreign medical schools, it could be considered constitutionally discriminatory to do so.

This adds support to our recommendations that U.S. students attending foreign institutions be treated equally when applying for student aid programs within the Department of Education, as they have in the past.

PREPARED STATEMENT

Thank you for the opportunity to present this statement to your Subcommittee.

[The statement follows:]

STATEMENT OF CHARLES R. MODICA

Mr. Chairman and Members of the Subcommittee, I am very pleased to appear before you today to discuss student financial assistance and issues related to health professions.

Student Aid

The President's budget proposal for FY'89 for student aid programs is vastly improved over past years. The demand and genuine need for federal resources for students seeking educational assistance continues to be significant. We are encouraged that additional resources have been recommended for Guaranteed Student Loans. This program is one of the only federal student aid programs in which U.S. students attending St. George's are able to participate. This is possible because, Mr. Chairman, during the Higher Education Act reauthorization of 1986, Congress provided a special GSL inclusion for students attending foreign medical schools that have a pass rate of 45% or higher on the examination administered by the Educational Commission for Foreign Medical Graduates (ECFMG). Under this inclusion, St. George's is the only Carribean institution that qualifies, because of its comparatively high pass rate. Federal student aid programs should be available for U.S. students wherever they choose to attend school.

Health Professions Graduate Education

Since St. George's was founded in August of 1976, nearly 1100 students have graduated with degrees in medicine, many of whom return to the United States to train practice in underserved areas. Often in inner-city area teaching hospitals that treat great numbers of low-income and indigent patient populations, 80-90% of residency positions are filled by graduates of foreigh medical schools. There would be a significant problem in handling the patient load in many of these hospitals if not for residency slots being filled by eager graduates from non-U.S. schools such as St. George's. The Journal of the American Medical Association, in its January 18, 1985 issue, reported that St. George's University School of Medicine had the highest initial pass rate of all the leading foreign medical schools in the world on the U.S. Qualifying Examination (the ECFMG). As each class at St. George's finishes its second year of medical education, approximately one-third of that class transfers to U.S. medical schools to complete their education.

I would like to advise you of a significant development that is central to the continued progress of our school as a recognized producer of quality medical graduates. The New York State Department of Education has reached a decision that approves the placement of third and fourth year students from St. George's to begin clinical clerkships at several of New York's teaching hospitals. About 60 of our third and fourth year medical students are engaged in two-year clerkships at Brooklyn Hospital, Methodist Hospital, and Coney Island Hospital, in Brooklyn.

The approval by New York, along with a similar 1985 decision by New Jersey, clearly demonstrates the confidence placed in St. George's by independent State Education Departments after on-sight reviews of our campuses. The approval by New York makes St. George's the only foreign school offering medical education in English that has an approved campus in New York State.

In 1986, Congress established the Council on Graduate Medical Education (COGME), an advisory body comprised of a representative sample of experts in medical education. The Council on Graduate Medical Education was asked to issue a report to the Secretary of HHS and the Congress to advise them how they should deal with issues related to Graduate Medical Education from the standpoint of public policy. This is the first time in almost a decade (since GMENAC) that the issue of Graduate Medical Education has been studied thoroughly and extensively by non-biased experts in the field.

The conclusions and recommendations of the Council are now being prepared for release to Congress in July. The COGME Subcommittee on Foreign Medical Graduates conclusions and recommendations include:

- The same National Board of Medical Examiners (NBME) exam should be administered to foreign or U.S. medical graduates if that is the only means to insure comparability of the exams; FMGMES vs. NBME.

- Foreign medical graduates and U.S. medical graduates should not be treated separately and unequally, and that selection into graduate medical education should be based on individual competence, not on group association.

- If the government has no rational basis for denying public funds for graduates of foreign medical schools, it could be considered constitutionally discriminatory.

Mr. Chairman, frankly, we expected a witch hunt by the Council on Graduate Medical Education in a campaign to wipe out opportunities for graduates of foreign medical schools. Instead, the Council made a very comprehensive and complete review of all of the issues related to foreign medical graduates and has developed conclusions and recommendations similar to what we have been stressing for several years. The Council on Graduate

Medical Education has now added important credibility to these arguments, that, I believe, should be carefully considered.

This adds support to my earlier recommendations that U.S. students attending foreign institutions should be treated equally when applying for student aid programs within the Department of Education.

Thank you for the opportunity to present this statement to your Subcommittee. We would be very pleased to work with you on these important, complex issues.

Senator CHILES. How many students do you have or do you enter in the class, the average class, and how many of those are from the United States? Would you say it is about one-third of your students?

Mr. MODICA. The average class size is about 80 students, and probably 90 percent of them are U.S. citizens.

Senator CHILES. It's 90 percent?

Mr. MODICA. Yes; 90 percent.

The next largest country, other than Grenada itself, where we have scholarship students would be Nigeria, after the United States.

Senator CHILES. About how many students from Grenada are there a year?

Mr. MODICA. We take in five on full scholarship per year. We also take students from the island of St. Vincent, where we also have a campus. We take two from St. Vincent each year also.

Senator CHILES. And St. George's, how is it funded?

Mr. MODICA. By tuition revenues solely.

Senator CHILES. Tuition revenues?

Mr. MODICA. That's correct.

We don't draw any support from the Grenadian Government. In fact, we have contributed over $1 million to the Grenada hospital from our own resources. So it is kind of the reverse that goes on in the United States, where the government helps the school. We kind of help the government.

Senator CHILES. Who started the school? I believe you said it was started in 1976.

Mr. MODICA. That's correct.

It was started by a group of physicians, all of whom had a son, or in one case a daughter, who were unable to gain admission to an American medical school.

Senator CHILES. Well, it sounds like you are doing very well down there.

How is Grenada doing right now?

Mr. **Modica**. It is somewhat better than it was a few years ago. The development needs to be continued before we can, you know, beat our chest about it, I suppose.

Senator **Chiles**. We thank you for your appearance here today.

Mr. **Modica**. Thank you.

STATEMENT OF MARCELLUS GRACE, PH.D. DEAN, XAVIER UNIVERSITY COLLEGE OF PHARMACY, LOUISIANA

Senator **Chiles**. Now we will hear from Dr. Marcellus Grace, the dean of Xavier University College of Pharmacy.

Dr. **Grace**. Good morning, Mr. Chairman.

Joining me is Dean Pat Wells, who is the next speaker, and is the treasurer of the Association of Minority Health Professions Schools.

I also serve as the president of the Association of Minority Health Professions Schools.

It is indeed a pleasure to be before you again this morning to discuss the Excellence in Minority Health Education and Care Act.

First, please allow me to express our gratitude to you for providing the fully authorized level of funding in fiscal year 1988 for this important program during the conference of the continuing resolution.

We fully recognize that your subcommittee was working under great budgetary pressure at that time, and I cannot begin to tell you how much we appreciate the thoughtful consideration that you and your staff put into insuring the viability of this important new centers concept last year.

The purpose of the Excellence in Minority Health Education and Care Act is to strengthen our national capacity to train minority students in the health professions and to support health professions schools which have trained a significant number of the Nation's minority health professionals to serve minority populations in underserved areas.

The Excellence in Minority Health Education and Care Act will provide resources for increased recruitment and retention of minorities and other disadvantaged populations to enhance their accessibility to quality health professions education.

The institutions included in the authorization had proposed a concept and had worked hard with the Labor and Human Resources Committee in the Senate and the Health and the Environment Subcommittee in the House to develop the legislation.

The authorization of the Centers of Excellence in Minority Health Professional Education and Care was based on several findings that I would want to mention now.

First, blacks are significantly underrepresented in the health professions, constituting less than 3 percent of physicians, dentists, pharmacists, and veterinarians, compared to a population ratio of 12 percent.

Blacks experience an astounding health status gap that results in 60,000 more deaths among blacks in this country each year than would occur if blacks had the same age adjusted death rates as whites.

Together, these eligible institutions have more than 300 years of experience in minority health professions education. To a much greater degree than for other institutions, the graduates of these institutions have elected to serve in underserved communities, with a large percentage of blacks and other minorities as their patients.

Third, with adequate followup funding, such as the Centers of Excellence in Minority Health Professional Education, these institutions should become national models of effective and efficient programs to significantly improve minority representation in the health professions and minority health status.

Mr. Chairman, during your subcommittee's consideration of this important program, it is our hope that everything possible will be done to continue to insure that the centers concept, which is such an integral part of this legislation, be maintained and fully supported.

To accomplish that, we urge that during your consideration, the following steps should be taken.

First, include the important historical background and unique experience of these institutions as part of the criteria for funding.

Second, limit the number of centers to a number that can be adequately funded to develop the Centers of Excellence concept. To do less would doom the institutions to failure in this important venture.

Carefully review the entire history and intent of this important legislation, and assure that adequate funding be provided in fiscal year 1989 that would insure the current support.

PREPARED STATEMENT

Again, let me thank you and the committee for the hard work last year. I would like to take any questions at this time.

Senator CHILES. Thank you.

We are delighted to have your testimony. We will see what we can do.

Dr. GRACE. Thank you.

[The statement follows:]

STATEMENT OF MARCELLUS GRACE

Mr. Chairman and Members of the Subcommittee, I am very pleased to appear before you today to discuss the Excellence in Minority Health Education and Care Act.

First, please allow me to express our gratitude to you for providing the fully authorized level of funding in fiscal year 1988 for this important program, during the conference of the continuing resolution. We fully recognize that your Subcommittee was working under great budgetary pressure at that time, and I cannot begin to tell you how much we appreciate the thoughtful consideration that you and your staff put into insuring the viability of this important new centers concept.

The purpose of the Excellence in Minority Health Education and Care Act is to strengthen our national capacity to train minority students in the health professions and to support health professions schools which have trained a significant number of the nation's minority health professionals to serve minority populations in underserved areas. The Excellence in Minority Health Education and Care Act will provide resources for increased recruitment and retention of minorities and other disadvantaged populations to enhance their accessibility to quality health professions education.

The institutions included in the authorization had proposed, a concept and had worked with the Labor and Human Resources Committee in the Senate and the Health and the Environment Subcommittee in the House to develop the legislation. The authorization of the Centers of Excellence in Minority Health Professional Education and Care was based on several findings:

1) Blacks are significantly underrepresented in the health professions constituting less than 3% of physicians,

dentists, pharmacists and veterinarians compared to a population ratio of 12%. Blacks experience an astounding health status gap that results in 60,000 more deaths among blacks in this country each year than would occur if blacks had the same age adjusted death rates as whites.

2) Together, eligible institutions have more than 300 years of experience in minority health professional education. To a much greater degree than for other institutions, the graduates of these institutions have elected to serve in underserved communities, with a large percentage of blacks and other minorities as patients;

3) From 1982 through 1987, these institutions, under a management agreement with the Department of Health and Human Services, had gone through a financial distress phase-out program, and had demonstrated significant improvement in the quality of managerial and academic programs;

4) The need of the black community is such that Centers of Excellence should be fully supported. Inadequate support will only perpetuate the historic struggle of these institutions, but in a more difficult environment; and

5) With adequate follow-up funding as Centers of Excellence in Minority Health Professional Education, these institutions should become national models of effective and efficient programs to significantly improve minority representation in the health professions and minority health status.

Mr. Chairman, during your Subcommittee's consideration of this important program it is our hope that everything possible will be done to continue to insure that the centers concept, which is such an integral part of this legislation be maintained and fully supported. To accomplish that, we urge that during your consideration, the following steps be taken:

- o Review the concept of the Centers of Excellence in Minority Health Education and Care, including both the background need and the strategy proposed;
- o Include the important historical background, contribution and unique experience of these institutions as part of the criteria for funding;
- o Limit the number of Centers to a number that can be adequately funded to develop the Centers of Excellence concept. To do less would doom the institutions to failure in this important venture;
- o Carefully review the entire history and intent of this important legislation to establish the guidelines and criteria for participating in this program; and
- o An adequate increase in funding be provided for fiscal year 1989 that would insure current program support and modest growth for coming years.

The concept of Centers of Excellence in Minority Health Professional Education and Care recognizes that the mission of the eligible institutions is consistent with a national need and concern. Yet, the historic financial struggle of these institutions has been inherent in their mission. Just as the nation supports the mission of other institutions through other mechanisms, the Centers of Excellence is a mechanism for supporting the critical mission of these institutions.

Again, Mr. Chairman, please allow me to express our very deepest appreciation for the careful consideration and support that you and your Subcommittee have demonstrated while developing this important concept.

I am very pleased to respond to any questions you may have.

STATEMENT OF PATRICK R. WELLS, PH.D., DEAN, TEXAS SOUTHERN UNIVERSITY COLLEGE OF PHARMACY, AND TREASURER OF THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

Senator CHILES. Now we will hear from Patrick Wells, treasurer of the Association of Minority Health Professions Schools.

Dr. WELLS. Thank you very much, Mr. Chairman.

My name is Patrick Wells. I am dean of the College of Pharmacy and Health Sciences at Texas Southern University, in Houston, TX, and, as was mentioned, treasurer of the Association of Minority Health Professions Schools.

The association is a coalition of eight predominantly black health professions schools.

We would like to speak about the President's budget. We are heartened that the administration has focused a level of priority on biomedical research through NIH, and for AIDS related research and services.

We are concerned, however, that the President's budget again recommends that funding for health professions training programs be severely reduced, and administered as a block grant.

Student aid in the form of Pell grants and guaranteed loans appears to be adequately supported, but we are concerned that these increases may be at the expense of other important student aid programs.

The gains made in black enrollment and graduates in health professions education programs peaked in the mid-seventies. In recent years, the applicant pool of blacks and other minorities who seek health professions careers has declined significantly.

Health profession programs have had a tremendous impact on Federal efforts to supply the Nation with qualified health professionals. However, minority health professionals continue to experience severe shortages.

It is well documented that, while black health professionals serve all races, they are more likely to establish practices or serve in areas with high percentages of minorities.

Many of these areas are also health manpower shortage areas, as identified by the Federal Government. So, enhancing the number of minorities in the health professions is a good investment in many respects.

Unless health professions and student aid programs are adequately maintained and expanded, the numbers of minorities participating in the health professions will remain precariously low.

Institutional programs for strengthening historically black colleges and universities are very important to the continued development of many institutions that train a great number of blacks and other minorities.

We are pleased that the President's budget proposal includes funding for this program and recommend that the committee give consideration to providing $15 million for this important initiative for fiscal year 1989. Now more than ever before the institutions of our association have begun to participate more heavily in biomedical research activities through the National Institutes of Health and other Federal agencies.

The Research Centers at Minority Institutions Program, supported by your subcommittee, has proven a very valuable mechanism in the continued development of our institutional research capability.

In order to maintain the RCMI programs, our association recommends a fiscal year funding level of $17 million for RCMI.

Our association also recommends that NIH guidelines be changed that would allow RCMI funding received by our institutions to be included when making consideration for biomedical research support grants.

The association is also very supportive of the minority biomedical research support programs, and the Minority Access to Research Careers Program. We encourage your subcommittee to provide adequate resources to fund these initiatives. Further, we believe a review of the stipend levels for these programs is due.

We would also like you to consider this year the Federal facilities construction system. We noted previously our ability in training faculty in research capabilities. We hope that the Federal facilities renovation and construction resources will be funded this year.

PREPARED STATEMENT

Mr. Chairman, on behalf of the association, we would like to thank you for all of your efforts in our behalf in the past. We thank you for the occasion to present this testimony to you.

Thank you.

Senator Chiles. Thank you, sir.

We thank you both for your testimony.

[The statement follows:]

STATEMENT OF PATRICK R. WELLS

Mr. Chairman and members of the Subcommittee, I am very pleased to appear before your Subcommittee to discuss FY'89 funding for health professions training, biomedical research and student and institutional assistance.

The Association of Minority Health Professions Schools (AMHPS) includes the Morehouse School of Medicine, Xavier University College of Pharmacy, Meharry Medical and Dental Colleges, Florida A&M University College of Pharmacy, Texas Southern University School of Pharmacy and Health Sciences, Charles R. Drew Postgraduate Medical School and Tuskegee University School of Veterinary Medicine. The eight institutions of our Association have graduated 40% of the nation's black physicians and dentists, 50% of the nation's black pharmacists, and 75% of the nation's black veterinarians. Each of our institutions and the students who attend our schools rely heavily upon federal institutional and health professions programs. The collective and individual goals of our institutions to increase the number of black and other minority health professionals in the nation are affected profoundly by your Subcommittee's recommendations.

Mr. Chairman, your Subcommittee has played a very significant leadership role in insuring that adequate resources are provided to the federal programs of great concern to our Association, and we want you to know that we very deeply appreciate every consideration you and your magnificent Committee staff have given to these programs.

FY'89 President's Budget

The President's fiscal year 1989 budget proposal is in many ways distinct from those of past years. Because of the accord with Congress during last year's budget summit agreement, there is a limit to the Adminstration's ability to shift funding priorities from non-defense discretionary programs to defense related activities. In effect the Administration is only able to prioritize within each budget function or category, rather than shift resources anywhere they wish. We are heartened that the Administration has focused a level of priority on biomedical research through NIH, and for AIDS related research and services. We are concerned, however, that the President's budget again recommends that funding for health professions training programs be severely reduced, and administered as a block grant. This shortsighted plan does not make a great deal of sense.

The President's budget for education programs shows signs of life. Student aid in the form of Pell Grants and Guaranteed Loans appear to be adequately supported, but we are concerned that these increases may be at the expense of other important student aid programs. The same is true with institutional support. While we are very encouraged that support for strengthening Historically Black Colleges and Universities is maintained, it appears to be at the expense of other valuable institutional programs.

Health Professions and Student Aid

The gains made in black enrollment and graduates in health professions education programs peaked in the mid-seventies. In recent years the applicant pool of blacks and other minorities who seek health professions careers has declined significantly. Four major factors that have led to the decline are (1) the continued lack of educational preparedness of these groups; (2) the attraction of these young students to other less rigorous, and more financially rewarding professions; (3) large debts incurred while training and the substantial debt burden facing minorities who pursue health professions careers. For example, the average debt in 1987 of a student graduating from the Morehouse School of Medicine is $49,000, compared to $32,000 just two years ago. This does not include any debt incurred during undergraduate education. These numbers are staggering to all of us -- but just imagine what they look like to a poor black kid from rural Georgia, and; (4) lack of knowledge of and access to potential financial resources to pursue a medical career.

The attrition rate of minorities in health professions schools has also been identified as a major problem. Comparatively, the retention rate of minorities is much lower than that of non-minorities. The reasons for this are not fully known, but it is clear that it is very important to keep these students enrolled once they are in school, given the already significant investment made in the nurturing of these students.

Health professions programs have had a tremendous impact on federal efforts to supply the nation with qualified health professionals. However, minority health professionals in the disciplines of medicine, dentistry, pharmacy, and veterinary medicine continue to experience severe shortages. While blacks represent approximately 12 percent of the U.S. population, only about 2-3 percent serve in these health professions.

Also, it is well documented that while black health professionals serve all races, they are more likely to establish practices or serve in areas with high percentages of minorities. Many of these areas are also health manpower shortage areas, identified by the Federal government, so enhancing the number of minorities in the health professions is a good investment in many respects.

Mr. Chairman, unless health professions and student aid programs are adequately maintained and expanded, the numbers of minorities participating in the health professions will remain precariously low. However, as suggested by the HHS Secretary's Task Force Report on Black and Minority Health, the health status of minorities will most likely improve with any increase in the number of minority health professionals. Your Subcommittee has demonstrated tremendous support in the past and recently, and Mr. Chairman, we appreciate it.

Higher Education Institutional Programs

Institutional programs for strengthening Historically Black Colleges and Universities are very important to the continued development of many institutions that train a great number of Blacks and other minorities. The strengthening grant programs for Historically Black Graduate Institutions are utilized to establish or strengthen the physical plants, financial management, academic resources, and endowments of HBCUs. A further use of the resources for the establishment of an endowment development office or to increase contributions from private sources is a very positive aspect of the program. The strengthening program for Historically Black Graduate Institutions is having a significant positive impact on our institutional capability to achieve these goals. As mentioned earlier, we are very pleased that the President's budget proposal includes funding for this program, and recommend that the Committee give consideration to providing $15 million for this important initiative for FY'89.

Minority Research Initiatives

Now more than ever before, the institutions of our Association have begun to participate more heavily in biomedical research activities through the National Institutes of Health and other federal agencies. Many of our schools have made significant advances in the development of our research infrastructure and investigational capabilities. The Research

Centers at Minority Institutions Program supported by your Subcommittee has proven a very valuable mechanism in the continued development of our institutional research capability, especially as it relates to studying diseases and health status factors that are more prevalent among blacks than the general population. One example of this is the initiative taken by the Division of Research Resources to utilize a portion of the NIH AIDS funding to integrate programs at minority institutions that will accelerate the ability of these schools to study AIDS risk factors, and prevention techniques. The RCMI directors have just met recently to plan for program development in this area. Mr. Chairman, the RCMI program has allowed our schools to obtain state-of-the-art laboratory equipment and supplies, hire additional expert research faculty to complement existing staff, provide faculty development programs, create training opportunities for undergraduate and graduate students, and enabled us to fortify institutional services that support research and technical expertise. Most importantly, RCMI has served as a major stimulus in the ability of our schools to compete for other, more traditional sources of research funding. Xavier University College of Pharmacy has recently approved a Pharmacy Doctorate Program, and is now eligible to participate in the RCMI program. They have made a comprehensive grant application, and pending its approval will be the final AMHPS institution to receive a grant under this important program. In order to maintain the RCMI programs at the other institutions, and provide additional resources for the new Xavier program, as well as support supplemental requests, our Association recommends an FY'89 funding level of $17 Million for RCMI.

We would also like to continue to encourage the Committee to further explore how specific NIH Institutions could supplement RCMI programs with research funding provided by your Subcommittee, similar in scope to the AIDS effort, but on a larger scale, and related to the disease specific missions of the individual institutes. We believe that integration of resources into these existing programs could have a major impact on our knowledge of disease specific factors leading to the gap in health status among blacks when compared to whites.

Our Association also recommends that NIH guidelines be changed that would allow RCMI funding received by our institutions be included when making consideration for Biomedical Research Support Grants (BRSG), and that the principle investigator on other research grants. This would be perfectly consistent with traditional NIH funding of grant mechanisms and policy.

The Association of Minority Health Professions Schools is also very supportive of the Minority Biomedical Research Support Programs (MBRS), and the Minority Access to Research Careers Program (MARC). It is very important, in our view, that the focus of the MBRS program be shifted back to supporting minority students and faculty at minority schools, rather than the current situation that suggests as much as 70% of MBRS funds are being awarded to majority schools. We encourage your Subcommittee to provide adequate resources to fund those initiatives. Further, we believe a review of the stipend levels for these programs is due.

As you know, Mr. Chairman, the Authorizing Committees are considering a rewrite of the NIH statutory authority this year. Among the proposals being considered is a general facility construction authorization that has been missing for years. The state of biomedical research facilities in this nation is not positive, and we support the development of a well thought out authorization for extramural biomedical research facility construction.

The Association of Minority Health Professions Schools recognizes the importance of a federal facility construction system that utilizes peer review based on institutional capabilities, track record, and scientific merit. We do also recognize and urge that some federal resources be awarded to institutions based on the health status needs of our nation, and the needs and capabilities of the institutions that can have the greatest impact on addressing those needs. The historically Black health professions schools in this nation are demonstrating an emerging excellence and capability to train faculty, and study diseases that disproportionately affect minorities and we believe that when considering Federal facility renovation and construction resources, criteria should be developed that recognize these important unique capabilities.

Funding of construction for research facilities to eligible institutions that demonstrate emerging excellence in biomedical and behavioral research could be considered under the following criteria:

A. An institution that carries out research and training programs that has a special relevance to a problem, concern, or unmet need of the United States.

B. An institution that has already demonstrated a commitment to enhancing and expanding its research productivity.

C. An institution that has been productive in research or research training in the face of significant challenges such as the underrepresentation of minorities in health science careers; the health status disparity of a large segment of the population; or a regional disparity in health care technology or services that threatens to adversely affect health status in the future.

D. An institution that has a plan for research advancement, and the ability to carry out such a plan.

Our organization supports the funding recommendation of $8.5 billion for the NIH, in coordination with the Ad Hoc Committee for Medical Research Funding.

Mr. Chairman, thank you for the opportunity to present the views and recommendations of the Association of Minority Health Professions Schools. Again, we appreciate the support your Subcommittee has demonstrated to the programs supported by our Association. I am pleased to respond to any questions you may have.

STATEMENT OF WENDY J. WERTHEIMER, DIRECTOR OF PUBLIC AND GOVERNMENT AFFAIRS, AMERICAN SOCIAL HEALTH ASSOCIATION

Senator **Chiles**. ow we will hear from Wendy J. Wertheimer, director of public and Government affairs, American Social Health Association.

Ms. **Wertheimer**. Good morning, Mr. Chairman.

Mr. Chairman, since 1981 the attention of the Nation has been riveted on the AIDS epidemic. The other sexually transmitted diseases, if noticed at all, are dismissed——

Senator **Chiles**. Would you pull your microphone up just a little closer, please.

Ms. **Wertheimer**. The other STD's, if noticed at all, are dismissed as less dramatic, less deadly, and, thus, less important.

We now know, however, that these diseases are more dangerous than ever—as an important risk factor in the development of AIDS.

Yet, this administration continues to address the AIDS epidemic, to the exclusion of, and, more importantly, at the expense of research, prevention, and control of the other sexually transmitted diseases.

Studies consistently show that persons with STD's, particularly syphilis, herpes, chancroid, and genital warts, are at an increased risk of acquiring HIV. Each of these diseases is increasing in the United States.

In 1987, syphilis cases increased 25 percent nationwide over 1986. This was the largest increase in syphilis since the 1950's.

The State of Florida's increase was almost triple that amount.

These increases were primarily among heterosexuals.

Cases of antibiotic resistant gonorrhea have nearly doubled each year for the last several years, and, again, Florida has the honor of being the worst State in the Nation.

CDC's limited resources have been almost exclusively devoted to syphilis and gonorrhea. Other important diseases simply cannot be addressed. One of those diseases is chlamydia, which infects 4 million Americans each year. Herpes, a viral STD, from which 40 million Americans suffer, has been shown to be an important risk factor in AIDS, and yet receives virtually no State grant funds.

There are an estimated million cases of human papilloma virus each year, which is linked to cervical cancer, killing 7,000 women each year. And, again, HPV receives no funds under the CDC program.

STD programs have suffered from the diversion of millions of dollars of funds to AIDS. Of equal concern is the diversion of trained, experienced STD program personnel, both in the headquarters and in the field.

Even those people who remain in the STD division spend significant proportions of their time and energy working on AIDS. A recent study showed that only 6 of the more than 90 total STD staff actually spend all their time on STD's.

The rationalization that diverting resources from STD control to AIDS would ultimately also benefit prevention of other STD's was clearly a mistake, and a tragic one. Sexually transmitted diseases, with 13 million new cases each year, are, in fact, creating a much larger reservoir of HIV infection in our society.

PREPARED STATEMENT

We cannot continue to address AIDS without also addressing other STD's which now put millions of Americans at higher risk of acquiring HIV.

Thank you, Mr. Chairman.

Senator CHILES. Thank you.

I think you point out something which is evident and true, and we are going to try to do something about it.

[The statement follows:]

STATEMENT OF WENDY J. WERTHEIMER

Mr. Chairman, I am Wendy Wertheimer, Director of Public and Government Affairs of the American Social Health Association. Our organization is celebrating its 75th anniversary and is the only national nonprofit organization dedicated solely to the control of all sexually transmitted diseases, including AIDS.

On behalf of our Board of Directors, I want to express our gratitude for the support this Subcommittee has shown for funding of AIDS activities and for the Sexually Transmitted Diseases Control program of the Centers for Disease Control.

Since 1981 the attention of the nation has been riveted on the AIDS epidemic. As a consequence, the other sexually transmitted diseases, which have never been given due consideration among the nation's health priorities, have been completely overshadowed. If noticed at all, they are dismissed as less dramatic, less deadly, and thus less important. We now know, however, that these diseases are more dangerous than ever—as an important risk factor in the development of AIDS.

Yet this Administration continues to address the AIDS epidemic to the exclusion of, and more importantly, at the expense of, research, prevention and control of the other sexually transmitted diseases. Since 1981 the STD control program has been subjected to two proposed block grants, reprogramming of funds, cuts in funds, the Gramm-Rudman-Hollings sequestration, a hiring freeze, and the direct diversion of funds and personnel to AIDS activities. Last year the President's budget requested a cut in funds, and this year the President's request would freeze funding at last year's level provided by Congress. This Administration has never requested any increase in funds for STD efforts.

Adjusting for inflation, 1943 was the year of the greatest federal support for STD control programs. In 1988 dollars, we would have to spend $250 million to equal the federal effort of 1943, when the program consisted only of syphilis control. Today the federal government spends only one-quarter that amount to combat all sexually transmitted diseases.

We are trying to contain a four alarm fire with a few buckets of water.

STDS AS RISK FACTORS IN AIDS

STDs are important and dangerous in their own right. But we now know that these diseases are even more ominous. Studies show that infection with certain STDs, particularly those which break down the skin, are emerging as strong risk factors for acquiring HIV infection.

In Africa, the high prevalence of STDs may provide an explanation for the predominantly heterosexual pattern of HIV transmission. For example, the rate of syphilis in Africa is between 100 and 300 times higher than rates of syphilis in the U.S. Early studies from Africa found a markedly increased risk of HIV infection among persons with ulcerative STDs. STDs increased risk threefold or more.

Recent studies conducted in the U.S. support these findings. A study in a Baltimore STD clinic found elevated risk for HIV infection associated with each STD investigated—syphilis, gonorrhea, hepatitis, genital herpes, and genital warts. Among men, syphilis was an independent risk factor, doubling risk of HIV. Among women, genital warts (HPV) were identified as an independent risk factor, also doubling risk. Studies in San Francisco and Seattle have shown that preceding infection with genital herpes significantly increases risk of HIV infection.

Thus, evidence is consistent in showing that persons with STDs, particularly syphilis, herpes, chancroid and genital warts are at heightened risk for HIV infection. These four diseases will afflict more than 40 million Americans this year; and herpes and genital warts, which are caused by viruses, are incurable. Each of these diseases is increasing in the United States.

INCREASED RATES OF STDS

The incidence of STDs responds directly to the commitment—or lack of commitment—of federal support. As the attached chart shows, incidence of syphilis has increased as funding available for syphilis control has dropped. Although syphilis has been a priority for the STD program, actual funding available for syphilis control has decreased over the past decade. This decrease was due to a number of factors including diversion of funds, inflation, and program initiatives for pelvic inflammatory disease and penicillin-resistant gonorrhea.

In fact, in FY 1987 syphilis cases increased 25% nationwide over FY 1986. This was the largest increase in syphilis since the 1950s. In some states, such as New York, Florida and California, syphilis increases in FY 1987 averaged almost 70% higher than the previous year. In men syphilis rates increased 19%, while among women rates increased 32.9%. These increases were primarily among heterosexuals, and have the added danger of being a harbinger of future increases in congenital syphilis infection.

The number one reportable communicable disease continues to be gonorrhea. The problem of gonorrhea strains which are resistant to antibiotic has grown to epidemic proportion, and has become more widespread and more complex in the past year. Cases of antibiotic resistant gonorrhea have nearly doubled in each of the last several years.

Chancroid, a disease which is more common than syphilis in Africa but which has not been prevalent in the U.S., has increased by more than 50% each year since 1981. In 1986, the number of cases of chancroid increased 65% over the previous year.

With limited resources and personnel, the STD control program has been forced to make difficult trade-offs. Its resources have been almost exclusively devoted to the control of syphilis and gonorrhea, which are treatable and preventable. Other important diseases simply cannot be addressed.

One of those diseases is chlamydia, which infects more than 4 million Americans each year. Chlamydia can lead to sterility and can be passed on to a baby of an infected mother. In 1986 CDC published national guidelines for chlamydia control and testified before Congress last year that a national prevention program for this important public health problem would require $60 million per year. Yet these funds have never been requested.

Herpes, a viral STD from which 40 million Americans suffer has been shown to be an important risk factor in AIDS. Yet genital herpes efforts still receive virtually no resources from STD state grant funds. Manpower and resources do not exist to deal effectively with other viral STDs such as human papilloma viruses. There are an estimated 1 million new cases of HPV each year. This virus has been associated with cervical cancer which kills more than 7,000 women each year. It, too, may be a risk factor for AIDS, yet no state grant funds are available for the control of this disease.

DIVERSION OF RESOURCES AND PERSONNEL

STD programs have suffered from the diversion of funds to AIDS. At the beginning of the AIDS epidemic, resources and manpower were mobilized to meet the need of this important new disease, which was appropriate. However, in the years that have passed, these resources have not been restored. Millions of dollars have been diverted from STD programs to AIDS activities. Even as recently as 1987 $2.6 million were "borrowed" from STD activities to support AIDS initiatives. Although these funds were replaced at the end of the year, these resources were unavailable to STD efforts during that year.

Of equal concern is the diversion of trained, experienced STD program personnel, both headquarters staff and federal assignees in the field. Good people are difficult to find, and these experts, representing years of training and expertise, have not been replaced.

The brain drain has been severe and constant. In 1981, 4 STD division members were assigned responsibility to review the literature and investigate the public health implications of AIDS. In 1982, 8 members of the STD division were detailed to AIDS. In 1983, 5 headquarters staff and 20 field staff were reassigned to AIDS activities. In 1985, the Director of the Division of STDs was detailed to AIDS for part of the year, and 30 positions were diverted to AIDS. In 1986 45 positions from the STD program were diverted to AIDS programs.; and in 1987 those 45 positions were permanently reassigned to AIDS activities.

A major loss to the program does not show up on budget sheets or FTE allocations. The fact is that even those people who remain in the STD division spend significant portions of their time and energies working on AIDS. A recent study showed that only 6 of the more than 90 total STD staff actually devote all of their time to STD activities. Twenty-nine said they spent up to 49% of their time on AIDS; 23 spent 50 to 70% of their time on AIDS; and 38 members of the STD staff said they actually spent between 70 and 100% of their time working on AIDS.

The rationalization that diverting funds from STD control to AIDS would ultimately also benefit prevention of these other diseases was clearly a mistake, and a tragic one. Quite the opposite has happened. Although rates of STDs have decreased among homosexual men, heterosexual STD cases are increasing at rates unparalleled in 30 years.

The STD control program has never had the resources necessary to deal even with the epidemics of syphilis and gonorrhea. Long before AIDS and without any significant increases in funds the program had to begin addressing the epidemics of penicillin-resistant gonorrhea and of chlamydia. Viral diseases such as herpes and human papilloma viruses threaten millions of Americans, but now the STD program has had its funds and resources diverted to AIDS.

This year 13 million Americans will acquire a sexually transmitted disease. More than 100,000 women will be rendered sterile by an STD. More than 2 million couples will seek fertility services. Thousands of babies will be born with STDs, and others will die.

And, these widespread sexually transmitted diseases, affecting as many as 1 in every 5 adults are, in fact, creating a larger reservoir of infection of HIV in our society.

We cannot continue to address AIDS without also addressing other STDs which now put millions of Americans at higher risk of acquiring HIV. It is said repeatedly that education is the only tool we have to prevent AIDS. But the fact is we have another critically important and cost-effective tool--control and prevention of other sexually transmitted diseases.

We have several recommendations:

* To increase FTEs for STD control programs and increase training to build a corps of professionals who can deal with all sexually transmitted diseases, including AIDS. The program cannot continue to function with part-time staff.

* To provide demonstration programs of innovative models for comprehensive STD/AIDS services through community-based integrated health services.

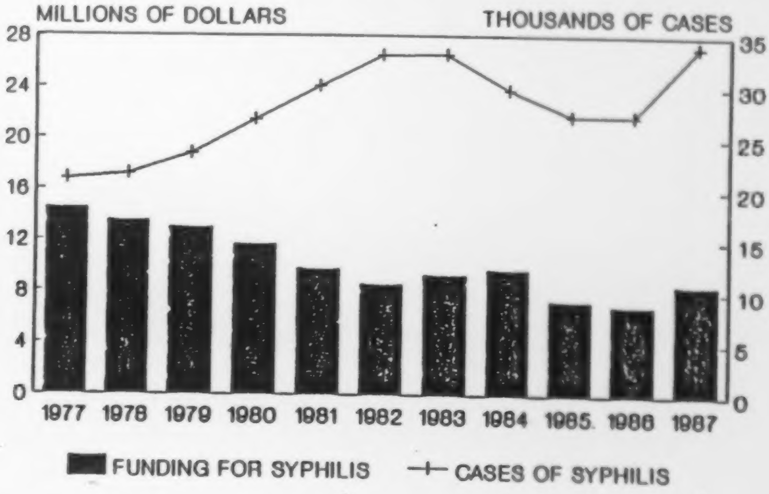
* To increase appropriations for STD control to allow a viable nationwide program with the capacity to address all the ulcerative STDs

which are implicated as risk factors in AIDS. We recommend an increase of $100 million over the President's budget request.

*To provide a special emphasis program at the National Institutes of Health for research on sexually transmitted diseases. Intensive efforts must be placed on investigating the role of STDs as risk factors in AIDS and on prevention measures which could benefit in the control of these diseases. Despite report language each year from this Committee, research on these diseases has not increased even enough to keep up with inflation.

The hope that fear of AIDS would prevent other STDs was a false one. Instead we must invest in prevention and control of sexually transmitted diseases as an important component in preventing transmission of HIV.

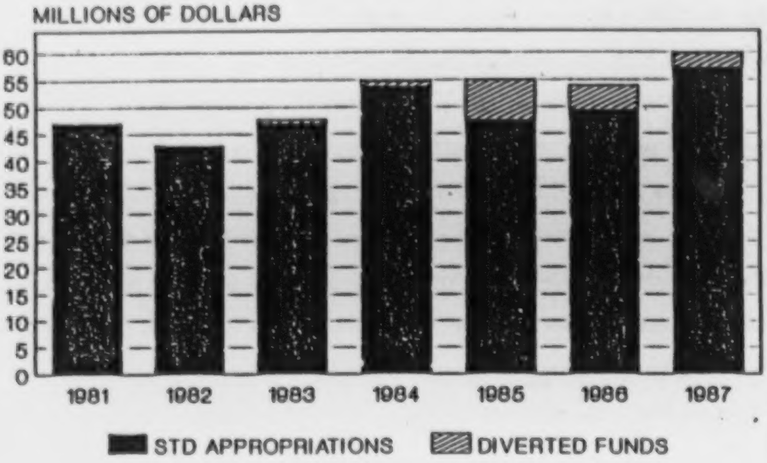
We appreciate the opportunity to present our views.



CASES OF PRIMARY & SECONDARY SYPHILIS VS FEDERAL GRANTS TO STATES

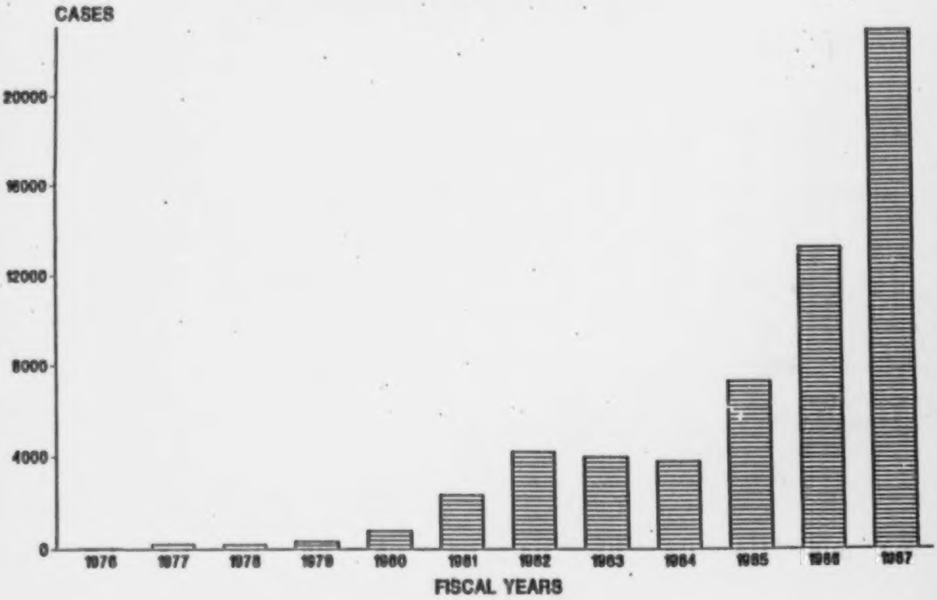
IN 1984 DOLLARS SOURCE: CDC

CDC STD FUNDING AND FUNDS DIVERTED TO AIDS ACTIVITIES

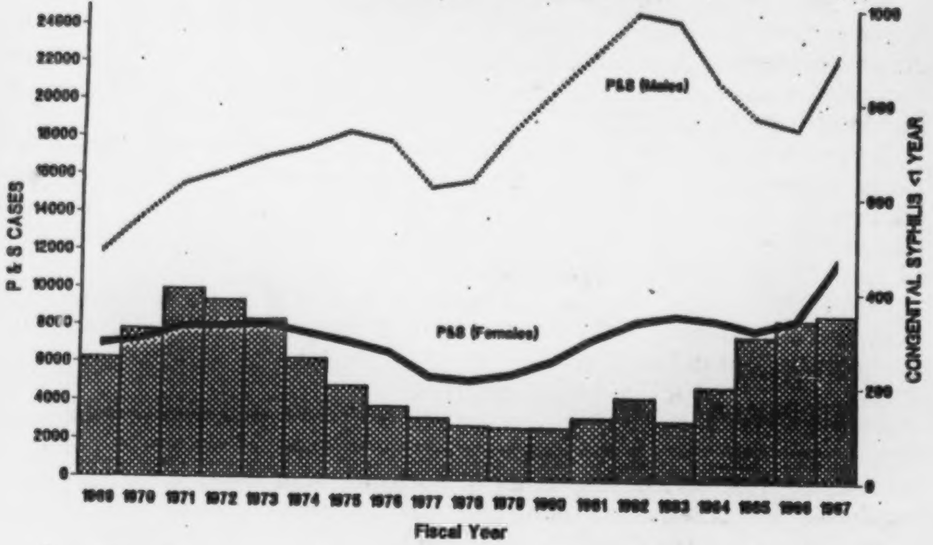


SOURCE: CENTERS FOR DISEASE CONTROL

RESISTANT STRAINS OF GONORRHEA UNITED STATES, FISCAL YEARS 1976 -1987

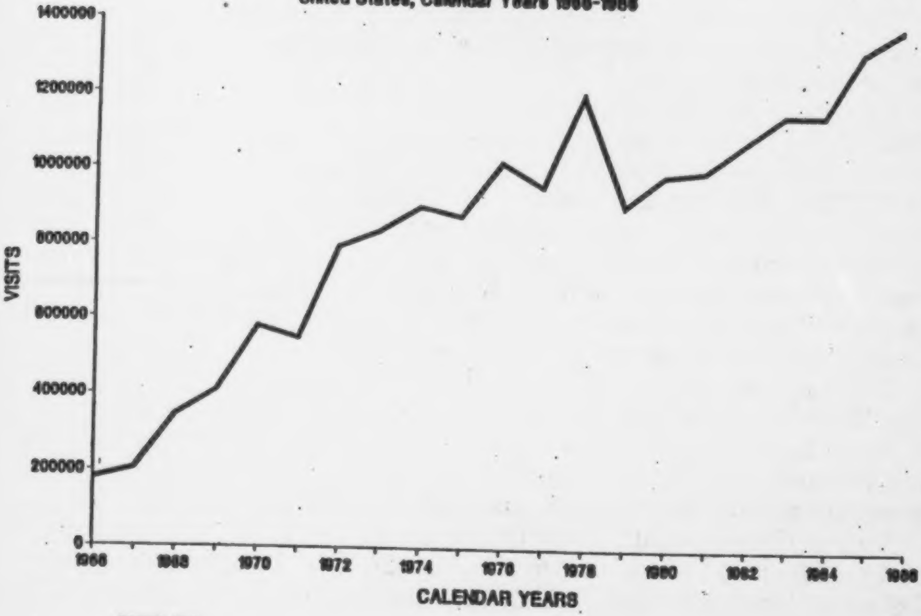


Primary and Secondary Syphilis Cases by Sex, and Congenital Syphilis (<1 Year) Cases, United States, F.Y. 1969-1987



Source: CDC 73.688

**Genital Warts
Number of Visits to Private Physician's Offices
United States, Calendar Years 1966-1986**



SOURCE: NDTI

STATEMENT OF SCOTT D. BALLIN, CHAIRMAN, COALITION STEERING COMMITTEE, COALITION ON SMOKING OR HEALTH

Senator CHILES. Now we will hear from Scott Ballin, chairman of the Steering Committee, Coalition on Smoking OR Health.

Mr. BALLIN. Thank you, Mr. Chairman.

I am Scott Ballin, vice president and legislative counsel for the American Heart Association. Today I am appearing before this subcommittee as chairman of the Steering Committee of the Coalition on Smoking OR Health.

Six years ago, the American Heart Association, the American Lung Association, and the American Cancer Society decided to join legislative forces in the battle against what the Surgeon General has described as the largest avoidable cause of death and disability in the United States—cigarette smoking.

Since that time, the Coalition on Smoking OR Health has supported a broad range of initiatives, including funding for the Office on Smoking and Health. The coalition urges this subcommittee to fund the OSH at a level of $5 million.

As you know, the Office on Smoking and Health is the Federal focal point for all Department of HHS tobacco- and health-related activities. The office serves as a national and international clearinghouse for scientific, technical, and general public information regarding cigarette smoking and the use of smokeless tobacco.

The functions of the Office on Smoking and Health are diverse, but fall generally into three categories: collection and dissemination of scientific and technical information; public education; and required reporting activities to the Congress.

Through various legislative mandates, Congress has in recent years imposed new responsibilities on the office, without providing an increase in funding.

For example, legislation enacted in the 98th Congress requires the office to staff the interagency Committee on Smoking and Health, prepare a biennial report to Congress on the activities of the office, the private sector, and efforts undertaken by each of these to inform the public of the health hazards of smoking, and to prepare a biennial report to Congress detailing ongoing or proposed research activities on the health effects of tobacco additives, as well as any other information on those cigarette ingredients that pose health risks to smokers.

If I may repeat, while all of these activities have been added to the OSH mandate, no additional funds have been provided.

Mr. Chairman, this year, an estimated 300,000 Americans will die of smoking-related illnesses. Billions of dollars will be spent on smoking-related health care and lost productivity costs.

Yet, while smoking continues to exact too great a toll on our society, the costs would be much higher but for the efforts of the Office of Smoking and Health and the voluntary health community, for whom I speak.

The programs developed and implemented by the Office on Smoking and Health have added immeasurably to the gains that have been made in reducing the single most preventable cause of death in the United States.

PREPARED STATEMENT

The Coalition on Smoking OR Health urges Congress to provide adequate funding for this small, but effective, Federal office.

Thank you.

Senator CHILES. We thank you and appreciate your testimony.

[The statement follows:]

STATEMENT OF SCOTT D. BALLIN

The Coalition on Smoking OR Health welcomes this opportunity to comment on Fiscal Year 1989 appropriations for the Office on Smoking and Health (OSH).

The Coalition on Smoking OR Health, comprised of the American Cancer Society, American Heart Association, and American Lung Association, was formed six years ago in an effort to more effectively bring smoking and health issues to the attention of federal legislators and other public officials. These three voluntary organizations are among the oldest and largest organizations of citizen volunteers in the United States; together, they have a membership of approximately five million volunteers in addition to their full time professional and scientific staff.

The Coalition on Smoking OR Health urges the Senate Appropriations Subcommittee on Labor-HHS-Education and Related Agencies to fund OSH at $5 million with an FTE increase of 8 positions in FY 89. The Coalition called for a similar appropriation level in FY 88. It is our strong belief that these proposed increases are still appropriate and desperately needed in FY 89 for the following reasons:

1. Tobacco use continues to cost our society tens of billions of dollars annually in health care and lost productivity expenses. Reducing tobacco consumption is cost effective as well as responsible public health policy.

2. In recent years, additional responsibilities have been added to the OSH's agenda by legislative mandate without concomitant increases in the OSH funding level. Among the Office's added responsibilities are: collecting and analyzing information on cigarette and smokeless tobacco additives; producing a biennial status report on smoking to Congress; producing a biennial status report on smokeless tobacco to Congress; staffing the Interagency Committee on Smoking and Health; and developing educational programs and materials on smokeless tobacco.

3. When one takes into account the staggering fact that the tobacco industry spends more than $2 billion annually on advertising its products, it becomes obvious that even the

combined resources of the OSH and the voluntary health organizations, which I represent, are not sufficient to fully counteract the sophisticated advertising techniques employed by the industry to entice individuals to begin or to continue smoking.

The long-range goal of the Office on Smoking and Health (OSH), like ours, is to reduce the premature death, disability, and health care costs associated with smoking. To this point, OSH serves as the federal focal point for all Department of Health and Human Services (DHHS) tobacco and health-related activities and serves as a national and international clearinghouse for scientific, technical and general public information regarding cigarette smoking and the use of smokeless tobacco. The functions of the OSH are diverse but generally fall into three categories: collection and dissemination of scientific and technical information, public education, and reporting activities. A more detailed description of each of these areas follows.

Science and Technical Information

The OSH Technical Information Center (TIC) is the world's largest repository of current research in smoking and health. The TIC regularly disseminates information to over 5,000 researchers and health professionals. The TIC is the world's only international clearinghouse for scientific information on smoking and health, and it is recognized by the World Health Organization (WHO) as a WHO collaborating center.

The major publication of the OSH is the annual Surgeon General's Report on The Health Consequences of Smoking. This document is recognized throughout the world as the premier publication on current issues in smoking and health research. In 1986 the Surgeon General's Report examined the health effects of involuntary smoking. This report is the most comprehensive review of the subject ever conducted. The 1986 report is also groundbreaking in that for the first time in the 18 years history of the Surgeon General's report on smoking and health, the report on involuntary smoking addressed the hazards posed to non-smokers by exposure to tobacco smoke. The 1987 report, which was just recently released, focuses on smoking behavior and addiction.

The newly created OSH Epidemiology Branch conducts periodic surveys on the smoking habits and characteristics of various segments of the U.S. population; analyzes existing smoking and health data sources; and provides technical assistance to researchers and other health professionals involved in special analyses of smoking and health issues. The Epidemiology Branch is currently evaluating data obtained through the 1986 Adult Use of Tobacco Survey. The evaluation will include: analyses of attitudes toward exposure to environmental tobacco smoke; cessation methods; and the influence of parental smoking.

Public Information and Education

The public information activities of the OSH have been very successful. Television networks and stations have given OSH Public Service Announcements (PSAs) on the health consequences of smoking more free air time than those produced by any other Federal or non-Federal agency. A recent evaluation found that OSH PSAs aired an average of 25.8 times per month. Over 64 percent of these spots were aired during peak viewing times. The value of this air time is in excess of $10 million.

In conjunction with the Cancer Information Service of the National Cancer Institute (NCI), the OSH has developed public service announcements about the 800 number assistance service for smokers interested in or trying to quit. OSH's newest initiative informs the public of the risks posed to infants and young children by involuntary smoking.

As a result of the enactment of the Comprehensive Smokeless Tobacco Health Education Act of 1986 (P.L. 99-252), the Office has further been designated as the lead agency for the development of educational programs and materials about the health hazards of the use of smokeless tobacco products.

Information Collection and Reporting Activities

The regulatory and reporting activities of the OSH comprise an additional area of responsibility. The enactment of the Comprehensive Smoking Education Act (P.L. 98-474) in 1984 statutorily established the OSH and required the Office to perform several new functions. The legislation requires the Office to staff the Interagency Committee on Smoking and Health. In addition, OSH is required to prepare a biennial report to Congress on the activities of the OSH, the private sector, and efforts undertaken by each to inform the public of the health hazards of smoking. The first of these biennial reports, entitled Smoking and Health: A National Status Report, was issued in November 1986.

The Office is also charged with the important task of compiling and reporting on cigarette ingredients information to be supplied to the DHHS by cigarette manufacturers as mandated by P.L. 98-474. A listing of additives must be made available to individual members of Congress or committees upon request. The Secretary of the DHHS is further authorized to transmit a report to Congress detailing on-going or proposed research activities on the health effects of tobacco additives as well as any other information on those cigarette ingredients that pose a health risk to smokers.

The Comprehensive Smokeless Tobacco Health Education Act of 1986 (P.L. 99-252) contains provisions for collecting and reporting information on additives in smokeless tobacco products. In addition, this law requires a biennial report to Congress describing the effectiveness of health education efforts about the adverse health effects of smokeless tobacco use; smokeless tobacco consumption figures; a description of the health effects of smokeless tobacco use; and identification of health and consumption-related topics appropriate for further research.

In summary, the Coalition on Smoking OR Health believes that without the many functions performed by the OSH, the effort to educate the American public and the rest of the world about the health hazards associated with smoking would be far behind where it is today. The annual Surgeon General's Reports are looked upon internationally as the scientific references on smoking and health. OSH's collection and dissemination of the immense data base of smoking and health research, both completed and on-going, is an invaluable resource to scientists, health professionals and public health activists. The programs developed and implemented by OSH have added immeasurably to the gains that have been made in reducing the single most preventable cause of death in the United States: cigarette smoking. The Coalition on Smoking OR Health urges the Congress to provide adequate funding for this small but most effective Federal office. Hundreds of thousands of lives depend upon it.

STATEMENT OF PHILIP J. LANDRIGAN, M.D., M. Sc., D.I.H., PRESIDENT, ASSOCIATION OF UNIVERSITY PROGRAMS IN OCCUPATIONAL HEALTH AND SAFETY

Senator CHILES. Now we will hear from Dr. Philip J. Landrigan, president of the Association of University Programs in Occupational Health and Safety.

Dr. Landrigan.

Dr. LANDRIGAN. Good morning.

I am Philip Landrigan. I am professor of community medicine at Mount Sinai Medical School in New York City and chairman of the Association of University Programs in Occupational Health and Safety.

I am here this morning, Senator, to give you a three part message. The first component is that occupational disease is very highly prevalent in the United States today. Based on estimates which we have done in New York State and extrapolated to the Nation, we estimate that each year, occupational exposures are responsible for between 50,000 and 70,000 deaths from occupational disease.

We calculate further that occupational exposures are responsible each year for approximately 350,000 cases of disease. In many cases, these exposures took place in the past, but the diseases are occurring today. They include a range of illnesses, including mesothelioma and lung cancer in asbestos workers, lymphoma and leukemia in workers exposed to benzene, cancer of the bladder in chemical workers exposed to synthetic dyes.

We are aware of your interest, Senator Chiles, in diseases of the elderly, and it is our strong feeling, based on the research that our association has conducted, that some significant fraction of all cases of cancer in the elderly, of all cases of end stage renal disease in the aged, and some fraction of chronic dimentia and senility in elderly persons are the result of occupational exposures to toxins, such as lead and solvents and carcinogens.

We reckon that the annual costs of occupational disease in the United States is $6 billion.

Against that very substantial burden of death and disease and disability, there is only a thin line of defense, and that is the inadequate number of occupational physicians, occupational health nurses, industrial hygienists, and industrial safety specialists around the country. The number is already too small. It has been highlighted by the AMA as an underserved medical area. The number of people in training today is even smaller than was the case 7 or 8 years ago.

So, there are no immediate prospects for rectifying the present situation of inadequate manpower.

The third and final point that I wish to make to you is that the Nation's training centers, the 14 educational resource centers which are listed on page 5 in my testimony, scattered across the country, are currently struggling for their very existence. These centers, which are funded primarily by NIOSH, were established in 1976. In the seventies they did well, and their budget peaked at $12.9 million in 1980.

Since that time, under the heavy hand of the present administration, an effort has been made to zero out the funding for the educational resource centers. Indeed, had it not been for the wisdom and the generosity of the Congress, the educational resource centers would not exist today.

Each year since 1980, the Congress has resurrected the centers from the ashes of the administration's policy.

We appreciate the budgetary constraints under which you labor. We do not wish to make an outrageous request.

PREPARED STATEMENT

We do, however, come here before you today to request between $12 and $15 million. The lower end of this range is less than the budget which we had in 1980. Such a budget would enable us to meet cost-of-living increases, would enable us to give our students reasonable stipends and, possibly, to pay our faculty.

Thank you very much.

[The statement follows:]

STATEMENT OF PHILIP J. LANDRIGAN

My name is Philip J. Landrigan, M.D. I am Professor of Community Medicine and Director of the Division of Environmental and Occupational Medicine at the Mount Sinai School of Medicine in New York City. Also, I am President of the Association of University Programs in Occupational Health and Safety, the organization representing the nation's fourteen Educational Resource Centers (ERCs) in occupational safety and health.

The Current Status of Occupational Disease in the United States.

Occupational disease is highly prevalent in the United States today. Although eighteen years have elapsed since passage of the Occupational Safety and Health Act in 1970, success in reducing work-related illness has remained elusive. Mortality for certain forms of cancer appears to be increasing;[1] occupational exposures may account, at least in part, for this trend. Asbestos, although used less frequently than in the past, remains widely dispersed; approximately 10,000 asbestos-related deaths are expected to occur in the United States each year for the remainder of the century.[2] Silicosis, a disease recognized since antiquity, is still common among miners and foundry workers;[3] a recent review of OSHA inspection records indicates that levels of exposure to silica in 43 per cent of American ferrous foundries remain above legally mandated standards.[4]

Occupational diseases encompass a broad range of human illnesses.[5] They include lung cancer and mesothelioma in asbestos workers, cancer of the bladder in dye workers, leukemia and lymphoma in workers exposed to benzene, chronic bronchitis in workers exposed to dusts, disorders of the nervous system in workers chronically exposed to solvents, kidney disease in workers exposed to lead, premature senility in workers with chronic exposure to certain neurotoxins, heart disease in workers exposed to carbon monoxide, impairment of reproductive function in men and women exposed to lead and certain solvents, and chronic disease of the musculoskeletal system in workers who suffer repetitive trauma.

Recent data indicate that occupationally related exposures are responsible each year in New York State alone for 5,000 to 7,000 deaths and for 35,000 new cases of illness (not including work-related injuries).[6] These deaths due to occupational disease include 3,700 deaths from cancer (10% of 37,000 cancer deaths in the state each year), and between 1,000 and 2,800 deaths from pulmonary, cardiovascular, renal, and neurologic diseases (1 to 3% of 95,000 deaths each year from these causes).

Crude national estimates of the burden of occupational disease in the United States can be developed by multiplying the New York State data by a factor of 10. New York State contains slightly less than 10 per cent of the nation's workforce, and it includes a broad mix of employment in the manufacturing, service and agricultural sectors. Thus, it may be calculated that occupational disease is responsible each year in the United States for 50,000 to 70,000 deaths, and for approximately 350,000 new cases of illness.

The annual costs, direct and indirect, of occupational disease are great. In New York State, these costs are estimated to total at least 600 million dollars per year.[6] Extrapolating these data to the nation, the approximate annual cost of work-related disease (not including injuries) in the United States is calculated to be at least 6 billion dollars.

There are not enough trained professionals in the United States to combat occupational disease.

In considering the current burden of occupational disease in the United States, it is most important to understand that occupational diseases are almost entirely preventable. Because occupational diseases arise from man-made conditions, they can be prevented through alteration of those conditions.

Major impediments exist, however, to the detection, prevention and effective treatment of occupational disease. Two of these impediments are: (1) that there are an inadequate number of trained professionals in the United States in the four disciplines comprising occupational health - occupational medicine, industrial hygiene, occupational health nursing, and industrial safety; (2) the average physician in the United States receives only minimal education about the nature, prevention and treatment of occupational disease. A recent survey indicates that the average American medical student receives a total of only four hours training in occupational medicine in the four years of medical school. This lack of training results in large measure from the absence on most medical school faculties of even a single faculty member with specialty training in occupational medicine.

Underdiagnosis and misdiagnosis of work-related disease are well-documented consequences of the shortage of trained personnel in occupational health and of the inadequate training of American medical graduates.[6] In 1985, for example, when an estimated 3,700 deaths from occupationally-related cancer occurred in the State of New York, only three awards for occupational cancer were made in the state through the Workers' Compensation Program. Although many factors contribute to this enormous disparity, a major factor is the inability of most physicians to recognize work-related disease when they see it.

Proper diagnosis of occupational disease will not occur until we have in the United States an adequate supply of trained professionals in occupational medicine, occupational health nursing, industrial hygiene and industrial safety.

The Educational Resource Centers (ERCs).

The Educational Resource Centers (ERCS) were established by the Congress under Section 21(a) of the Occupational Safety and Health Act of 1970. In 1976, Congress authorized NIOSH to create 20 multi-disciplinary ERCs, regionally located at major universities throughout the country. Funding of each of these centers was envisioned by the Congress to be at least 1.0-million dollars per year.

Development of the ERCs began in 1976. By 1980, a funding level of 12.9-million dollars was reached and permitted support of twelve centers. In that year, over 100 different academic programs were active in these centers, offering degrees in occupational medicine, industrial hygiene, occupational health nursing, and occupational safety. The number of graduates of the ERCs virtually quadrupled from 1976 (176 graduates) to 1980 (747 graduates). Even more dramatic was the increase in continuing education programs offered to practicing professionals to upgrade their skills. In 1976, approximately 1,600 individuals attended such courses; by 1980, this number had increased to almost 10,000 persons.

Since 1981, funding for the ERCs has decreased drastically. Each year from 1981 through 1987, the Administration proposed elimination of the ERCs and elimination of the NIOSH extramural training budget. Last year, in fiscal 1987, the Administration requested 6.6-million dollars for the ERCs, but stated that this budget request represented the beginning of a three year phase-down which would "allow an orderly transition to other governmental and private funding sources."

Each year, since 1981, the Congress has seen fit to resurrect the ERCs from the Administration's policy. Thus, in 1981, the Congress voted a funding level of 8.7-million dollars. In 1982, the Congressional budget was 5.8-million dollars. In 1984 and 1985, despite additional attempts by the Administration to eliminate the ERC programs, Congress restored funding to a level of 8.7-million dollars. In 1986, Congress again supported the ERCs, but funding was reduced by the Gramm-Rudman-Hollings Bill to 8.4-million dollars. In 1987, the core funding for the ERCs was 8.5-million dollars, to which Congress added a supplement of 1.5-million dollars for training in research. In 1988, the core funding was again 8.5-million dollars plus a 1.4-million dollar research training supplement; 0.4-million dollars were required, however, to deleted from this total under the provisions of the Gramm-Rudman-Hollings bill. Thus since 1984, despite increases in the cost of living, no increases have occurred in the ERC program, no increases have been permitted in faculty salaries. and, most importantly, no increases have occurred in student stipends.

The effect of the Administration's policies in regard to the ERCs has been drastic. Rather than fostering an "orderly transition", the Administration's policies have led to a disorderly hemorrhage of precious national resources.

The freeze in core funding has had a significant negative effect on training programs in occupational health throughout the country. Two years ago, the University of Arizona was unable to maintain a full multi-disciplinary program and lost their ERC funding. Last year, programs at the University of Texas and the University of Illinois were in jeopardy of closing; forutnately, as the result of careful reprogramming, both are now expected to remain open this fall.

The locations of the current ERCs are as follows:

o	Alabama	School of Public Health University of Alabama in Birmingham.
o	California	School of Public Health University of California, Berkeley.
		Institute of Safety and Systems Management University of Southern California.
o	Ohio	Institute of Environmental Health University of Cincinnati
o	Massachusetts	School of Public Health Harvard University.
o	Illinois	College of Medicine University of Illinois in Chicago.
o	Maryland	School of Hygiene and Public Health The Johns Hopkins University.
o	Michigan	Center for Occupational Safety & Health Engineering The University of Michigan.
o	Minnesota	School of Public Health University of Minnesota.
o	New Jersey	School of Public Health Robert Wood Johnson (Rutgers) Medical School.
o	New York	Department of Community Medicine Mount Sinai School of Medicine.
o	North Carolina	School of Public Health University of North Carolina, Chapel Hill.
o	Texas	University of Texas Health Sciences Center School of Public Health, Houston.
o	Utah	Rocky Mountain Center for Occupational and Environmental Health, University of Utah.
o	Washington	School of Public Health & Community Medicine University of Washington at Seattle.

Rationale for Continuing Support of the ERCs.

The rationale for continuing to train professionals in occupational health is two-fold: (1) that occupational diseases are highly preventable; and (2) that prevention requires skilled diagnosis, thoughtful intervention and experienced follow-through of a sort that can only be provided by highly skilled professionals.

Occupational diseases are a major public health problem. They are not rare; they are not restricted to a small number of factory workers exposed to exotic hazards under unusual working conditions. Deaths and illness due to occupational disease are widespread in the United States and have the potential to affect citizens in every community throughout this nation.

Occupational diseases are extremely expensive.[6] They contribute significantly to the rapidly rising health care costs in the United States. However, unlike many contributors to this escalation, occupational diseases are entirely preventable through the conceptually straightforward approach of reducing occupational exposures to toxic substances.

Against the enormous burden of pain, suffering and fiscal expenditure which results each year from occupational disease and injury, we seek a modest level of support for the nation's ERCs. Specifically, we seek an appropriation of between 12- and 15-million dollars. The 14 ERCs and the other graduate and under-graduate programs supported by NIOSH through their extramural training budget constitute the nation's thin line of defense against occupationally-induced illness. Without the ERCs, occupational illness can only become more common. Without the hard work of the dedicated professionals trained in the ERCs, silicosis would be even more rampant than it is today, asbestosis would continue, occupational lead poisoning would blight the children of another generation of workers, and discovery of the toxic hazards of newly released chemical compounds would be made only after more workers had been injured and killed by those chemical compounds.

Support for continuation of the ERCs is widespread:

- The labor movement has always given unstinting support to the ERCs.
- The American Occupational Medical Association, which represents 4,000 physicians practicing occupational medicine in the United States, the majority of them in corporate settings, supports the effort of the ERCs to train professionals in occupational health; attached to this testimony is a letter of support from T. Forrest Fisher, M.D., President of the American Medical Association.
- Politicians of both major parties have strongly and consistently supported the ERCs. Four years ago, in Senate hearings to investigate a suspected excess in cancer mortality due to chemical exposures at the Hill Air Force Base in Utah, Senator Orrin Hatch stated "if there is a villain in this controversy, it is ingnorance; ignorance of the proper methods relating to the protection of the employees from harmful chemical exposures; ignorance

> of the scientific knowledge related to the effects of the worker's exposure to chemical substances; and ignorance of the now accepted fact that occupational causes of disease and illness often go undetected and unrecognized for a long period of time." The ERCs are dedicated to the eradication of this ignorance.

Two recent reports from the Congressional Office of Technology Assistance (OTA) support the conclusion that funding of the ERCs ought to be maintained. The OTA report "Preventing Illness and Injury in the Workplace" endorses the graduate training being provided by the ERCs and points out that cutbacks in federal training can be to reduce the number of trained professionals.[7] The OTA report "Reproductive Health Hazards in the Workplace" states "what is known about reproductive health hazards is far outweighed by what is unkown."[8]

A recent report from the Health Resources and Services Administration (HRSA) of the Public Health Service entitled "Education and Training for Health Risk Assessment and Management of Hazardous Waste" also emphasizes the importance of professional training through the ERCs. This report notes that "professional training cannot be instituted in the hazardous waste area without the ERC structure." It calls for more such training.[9]

I realize that in coming before you today to plead the case for continuing support of the ERCs, I do so in difficult times. The pressures of the federal deficit and the dilemma of the Gramm-Rudman-Hollings Act make it necessary for the Congress to make difficult decisions affecting the futures of universities. I can only say that we, in the universities, are fully aware of these difficulties, and we understand fully the need to make sacrifices on many fronts. Thus, we do not ask for any expansion of our present programs. We seek an appropriation of between 12- and 15-million dollars per annum. This sum will permit maintenance of our presently diminished programs and will restore cost-of-living increases that have not been met in the past eight years. Also, it will provide stability for the future to protect these frail programs against the further chaos of the disorderly phase-downs proposed by this current Administration.

The costs of occupational disease are massive. The cost of training professionals to prevent these diseases is minute. Training is, therefore, cost-effective. Perpetuation of training programs will save this nation millions of dollars and help to reduce spiralling health-care costs.

Thank you. I shall be pleased to answer any questions.

REFERENCES

1. Bailar JC III, Smith EM (1986). Progress Against Cancer? New England J. of Medicine 314:1226-1232.

2. Nicholson WJ (1985). Cancer from Occupational Asbestos Exposure: Projections 1965-2030. In I.J. Selikoff, ed. Disability Compensation for Asbestos-Associated Disease in the United States. New York: Mount Sinai Press.

3. Landrigan PJ et al (1986). Silicosis in a Grey Iron Foundry: The Persistence of an Ancient Disease. Scandinavian J. of Work and Environmental Health 12:32-39.

4. Oudiz J et al (1983). A Report on Silica Exposure Levels in United States Foundries. American Industrial Hygiene Association Journal 44:374-376.

5. W.N. Rom (ed) (1983). Environmental and Occupational Medicine. Boston: Little, Brown and Company.

6. Landrigan PJ, Markowitz SB (1987). Occupational Disease in New York State. Report to the New York State Legislature. New York: Mount Sinai Press.

7. U.S. Congress, Office of Technology Assessment. Peventing Illness and Injury in the Workplace. (OTA-H-256) Washington, D.C., April 1985.

8. U.S. Congress, Office of Technology Assessment. Reproductive Health Hazards in the Workplace. (OTA-BA-266) Washington, D.C., December 1985.

9. U.S. Public Health Service, Health Resources and Sciences Administration. Education and Training for Health Risk Assessment and Managment of Hazardous Waste, Washington, D.C., 1987.

LETTER FROM T. FORREST FISHER, M.D., PRESIDENT, AMERICAN OCCUPATIONAL MEDICAL ASSOCIATION

December 18, 1986

Philip J. Landrigan, M.D.
Director
New York/New Jersey Educational Resource Center
Mt. Sinai School of Medicine
1 Gustave Levy Place
New York, New York 10029

Dear Dr. Landrigan:

It is a pleasure to send you the enclosed correspondence from the American Occupational Medical Association supporting funding of the Educational Resource Centers.

The members of "The American Occupational Medical Association" want to work with your staff to provide clinical opportunities for your residents, students and trainees.

The demand for occupational safety and health professionals is greater than ever and through cooperative efforts, we can provide the trained professionals to meet the challenge.

Sincerely,

T. Forrest Fisher, M.D.
President
American Occupational
Medical Association

Senator CHILES. Thank you, sir.

How do you think we are doing now in regard to, say, the increase in the prevalence of these occupational diseases? We know that there are an awful lot of people that were earlier-on exposed to asbestos, in our shipbuilding, the way we use the material in housing, and many of these other things.

But for the current work force, for those people entering the work force, are their chances better? Are we doing anything about cleaning up some of these worksites, problems in the worksites? I'm talking now about everything from coal and black lung to all of the other things?

Dr. LANDRIGAN. Yes; we are doing better in some areas, Senator. Occupational lead poisoning is down. The use of asbestos is down. Silicosis is down. But there are lots of residual problems.

Briefly, they are in two areas.

First of all, despite some declines, there is substantial persistence of old-time diseases, and a lot of that persistence results from the fact that OSHA is simply not doing its legally mandated job inspecting workplaces.

Over 40 percent of workplaces, for example, still have excessive levels of silica dust; workplaces that use silica still have excessive levels of dust, foundries, in particular. That is, purely and simply, a failure of regulation. The hazards of silica have been known since the 1800's.

The other major problem is that new chemicals coming into the workplace are just not being adequately screened for their toxicity. The NAS, the National Academy of Sciences, did a review 3 years ago. They found that there is virtually no toxicologic screening data on something like 80 percent of the chemicals in commerce.

The EPA, although it is mandated to do screening under the Toxic Substances Control Act, has neither the will, nor the staff, nor the budget to do the job properly. And, as a consequence, new chemicals, many of them quite hazardous, are coming into the workplace with no checking whatsoever.

It is very hard to prove this because cancer takes several decades to develop after exposure to new chemicals. But many of us in the field are suspicious that the recently documented increase in cancer at several sites, such as multiple myeloma, may be due to exposure of workers and also exposure of the general public to these chemicals.

Senator **Chiles**. This is, again, lung cancer that you are talking about?

Dr. **Landrigan**. Yes, sir.

Senator **Chiles**. What kind of exposure do we know?

Dr. **Landrigan**. Well, we have something like 60,000 different chemical species in workplaces across the country, and about 10,000 of them have been checked for their hazards. There are a few surprises buried in there, I am afraid.

Senator **Chiles**. We thank you very much for your testimony.

Dr. **Landrigan**. Thank you.

STATEMENT OF LORRAINE JORDAN, C.R.N.A., M.S., DIRECTOR OF EDUCATION AND RESEARCH, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Senator **Chiles**. Now we will hear from Lorraine Jordan of the American Association of Nurse Anesthetists.

Ms. **Jordan**. Good morning, Mr. Chairman.

I am pleased to have an opportunity to address you today.

Many of you have had surgery and were administered an anesthetic. If you are within the statistical norm, over one-half of you sitting in this room today were administered your anesthetic by a nurse anesthetist.

I am representing that group of individuals. I am a certified registered nurse anesthetist, and I am representing the American Association of Nurse Anesthetists, with 24,000 members.

I am Lorraine Jordan.

Financial appropriations are of utmost importance to nursing anesthesia. The need for increased resources is essential to secure the educational future for nurse anesthesia.

I am here to ask for funding for a manpower study for student nurse anesthetists and for faculty development.

Why is there a need?

Here are some statistics to exemplify the need. Ten years ago, we graduated 1,000 nurse anesthetists a year. Today, when the need is much greater, we are only graduating 500 students.

The number of vacant positions has increased over 50 percent, with 250 job openings listed in our news bulletin alone. On a State level, the North Carolina Hospital Association has just issued a report in which they state they have 108 vacant, unfilled positions for nurse anesthetists.

The number of nurse anesthesia programs has decreased from 194 to 98 in the past 12 years, and the Department of Defense alone needs 1,700 nurse anesthetists to serve in the Reserves. And they have listed this as a national priority.

Remember, we are only graduating 500 students a year.

Therefore, a manpower study is needed to project the needs in the United States for nurse anesthesia services in the next 10 to 20 years. We request this committee direct the Department of Health and Human Services to study the need for nurse anesthesia services.

Why am I asking for nurse anesthesia training funds for students? Only 471 students receive nurse anesthesia training moneys. Students are required to hold full-time student status, and are unable to draw an added income to help alleviate the financial burden.

What can we do for funding faculty development? The Division of Nursing and the American Association of Nurse Anesthetists believe traineeship funds should be allocated specifically for faculty development.

The Nurse Education Act may not be authorized before this committee makes funding recommendations. Therefore, I urge this committee to fully fund nurse anesthesia programs at $800,000 in fiscal year 1989. The nurse education amendments adopted in 1985 have offered opportunity for better education and training, therefore, providing increased quality of care to you and your family.

PREPARED STATEMENT

The American Association of Nurse Anesthetists supports the National Center for Nursing Research and requests appropriations of $32 million for the fiscal year 1989.

Thank you, Mr. Chairman.

Do you have any questions or anything that I can assist you with?

[The statement follows:]

STATEMENT OF LORRAINE JORDAN

Mr. Chairman, I am Lorraine Jordan and have been a Certified Registered Nurse Anesthetist for 7 years. I have administered many anesthetics and have been a clinical and didactive faculty in a nurse anesthesia program for 6 years. Presently, I hold the position of Director of Education and Research for the American Association of Nurse Anesthetists (AANA). The 24,000 members of the AANA are pleased to have the opportunity to be represented before you again this year.

The testimony of this appropriation season sounds hauntingly similar to the sentiments of last year. Despite many efforts, the nurse anesthetists and the nursing community have had a difficult year. We are facing a pivotal decade. The decisions made today will shape future nursing roles in our hospitals, our clinics, our rural communities, our nursing homes and in our private homes.

The AANA believes that increased resources for nurse anesthesia education and research are essential to a secure future. Therefore, I would like to address most of my comments specifically to the Nurse Education Amendments and the National Center for Nursing Research (NCNR) at the National Institutes of Health (NIH), as it applies to the unique specialty of nurse anesthesia.

Any discussion about nurses and nursing cannot begin without discussing the nursing shortage. Unfortunately in 1988, the nursing shortage continues to impact the health care systems nationwide. The weakness pervades on our own Department of Defense and the National Institutes of Health. The rural areas continue to take the brunt of the crisis as more and more rural communities find themselves unable to find health care within their immediate community.

In spite of the nursing shortage, the applicant pool for Nurse Anesthesia Programs is lively. However, we are concerned about the impact the chronic shortage will have, not only in anesthesia but in all nursing specialties as well. With respect to the shortage in nurse anesthesia our data shows the following:

1) There are a total of 513 less anesthesia providers being educated per year now in the country than there were 10 years ago. Yet, the demand has clearly increased for both CRNA's and anesthesiologists in patient and outpatient anesthesia services;

2) The number of vacant positions for CRNA's has increased by 50%. We now have a current vacancy listing of more than 250 jobs per month;

3) The numbers of nurse anesthesia education programs has declined significantly since 1976 when there were 194 programs in the United States to a total of 98 in 1988; this reflects a 50% decline in programs and 50% reduction in total graduates as well.

4) The Department of Defense has indicated a need for 1,700 CRNA's in its Reserve Components alone, and have listed nurse anesthesia as a national priority in medical preparedness.

5) North Carolina exemplifies a state shortage of CRNA's currently having 108 unfilled CRNA positions. In a study conducted by the North Carolina Association of Nurse Anesthetists in conjunction with hospital administrators, they found this shortage is expected to increase to 183.6 positions in 5 years if nothing is done to alleviate the shortage.

In order to make a more accurate assessment of our national needs, we believe a manpower study is needed. We respectfuly request that the Committee direct the Departmentof Health and Human Services through report language in the FY 89 bill to study the nurse anesthesia manpower needs in the United States projected for the next 10 to 20 years. The results of such a study will clearly quantify the future manpower objectives of nurse anesthesia educational programs.

The AANA does not anticipate the number of CRNA's, nor the number of registered nurses in general to increase immediately. Nursing school enrollments continue to decline, the number of highschool graduates is decreasing and there is no anticipation that this trend is about to change during the next decade. Overall, enrollments in nursing have decreased dramatically. With respect to nurse anesthetists, in 1976 there were 1,094 graduates and there are 500 students projected to graduate in 1988.

Proposed solutions, commissions, papers and projects have been looked at, begun, and are ongoing, in the hope of finding an answer to the nursin shortage. The AANA supports these efforts. However, we do believe tha economics in the context of this nursing shortage is playing a key role. Generally, a nurses salary is not commensurate with the level of education, responsibilities, and work environment. In the case of CRNA's, Congress ha taken a giant step forward by enacting legislation to create a Part B fe schedule for CRNA services in 1986. This Committee created that legislation. We would also like to take this opportunity to thank the Committee for it past support for CRNA's. The legislation of OBRA of 1986 charged the Healt Care Financing Administration (HCFA) with developing regulations to implemen a fee schedule and payment methodology for CRNA's which is to become effectiv January 1, 1989.

We accepted as a condition of passage of that legislation Medicare assignment at a rate to be set by the HHS Secretary, as well as the need for suc payments to reflect budget neutrality. Since anesthesia fees have always bee reimbursed on the basis of a relative value scale under Part B, Medicare, w were surprised to learn that HCFA was considering a different methodology altogether under Part B for CRNA's; and one which would not pay for selected anesthesia services that CRNAs in many settings routinely perform. This methodology has not been tested and may well serve as a disincentive to CRNAs and their utilization. Moreover, it has the potential to adversely impact rural and small community hospitals as compared to urban/suburban hospitals. While CRNAs are certainly not expecting, nor do we seek equal pay with anesthesiologists, we do seek equity. But what has been happening at HCFA is what has been happening in hospitals across this country, throughout history. Nurses have, in effect been utilized to subsidize hospitals and hospital care; and today's bright, young professionals will not tolerate such a system and they are opting out of such professions--not only nursing but many of those in variety of allied health fields.

Several avenues are available to Congress to help nurses. The Nurse Education Amendments stand at the top of the list. Since their adoption in 1985, the amendments have provided valuable opportunities to nursing students. Our nurses are better educated and better trained. This is essential in providing the quality care needed in our changing health care setting. Today's hospitals are accommodating a larger percentage of critical care patients than ever before and we can expect this trend to continue. Therefore, preparation of well qualified nurse anesthetists is essential to match the increasing number and needs of critically ill patients requiring anesthesia services.

Nurse Anesthesia Traineeship Program:

Nurse Anesthesia programs are 24 to 36 continuous months in length, requiring full time student status. Because of the intensity of the work and required clinical time -- over 800 hours in the operating room delivering anesthesia--the nurse anesthesia students rarely are able to hold down a job while in school.

To enter a nurse anesthesia program, the students must hold current licensure as registered nurses and have a minimum of one year's experience in acute care nursing. The applicant must also hold a baccalaureate degree in nursing or a related field.

The average cost of a student, per year, to attend a nurse anesthesia program is about $13,000 to $19,750 at a state institution and $18,000 to $34,200 at a private institution. These figures do not include foregone income that the student would have had working as a critical care nurse with experience. The Division of Nursing had advised that in Fiscal Year 1987 only 471 nurse anesthesia students were able to receive funds from the Federal Nurse Anesthetist Traineeship program. It should be recognized that under current authorization, limited only to students beyond the 12 month level in the program, these students get less tha $2000 for this program.

Because of the expenses and heavy financial burden that is placed on nurse anesthesia students, we believe eligibility requirements should be expanded and opened to students who need financial assistance during the entire span of the nurse anesthesia education program.

Under current law, not more than 20% of the nurse anesthetist traineeship program money can be used for grants that provide financial assistance to support CRNA faculty. Available funding would allow faculty an opportunity to obtain a required advanced degree. This incentive is required to promote faculty development and provide the number of educators required to prepare future anesthesia providers.

Due to the current financial limitations of the program with a funding level of less than $80,000 none of this money has been used for the faculty development. The Division of Nursing and the AANA believe that Traineeship funds should be allocated specifically for the development of educators. The faculty development is required to expand current programs and open new programs.

Our estimates show that tuition for graduate education averages about $10,000 per year at a public institution and up to $30,000 per year in a private institution.

Knowing that the Nurse Education Act may not be authorized by the time this committee makes the funding recommendations, we strongly urge this Committee to fund nurse anesthesia programs at $800,000 in FY 89. We hope that when the authorization passes, that the Committee will favorably consider fully funding our proposals.

The establishment of the NCNR and the ongoing commitment from Congress and the research community sends a valuable and much needed statement of support to the nursing community. The action of this Committee can strengthen this statement for future nurses. AANA supports continued funding of the National Center for Nursing Research and request an appropriation of $32 million for FY 89. This would allow the Center to fund 25 more grants than the current fiscal year, and increase its focus in training more nurse researchers.

Past studies have indicated that the utilization of nurse anesthetists is cost effective. Continued support of these vital programs--the Nurse Education Amendments and the National Center for Nursing Research--will provide further opportunity to contain health care costs and research further cost effective techniques.

Thank you for the opportunity to appear before you today. I would be happy to answer any questions.

Senator CHILES. Well, I note that you talk about all of the shortages that are out there and that there is something wrong with the sort of supply and demand and the fees, the salaries, the earnings that the anesthetists receive.

Is there also a shortage of anesthesiologists?

Ms. JORDAN. Yes, sir; there is.

Senator CHILES. So we are not in a fight here now between anesthetists and anesthesiologists.

Ms. JORDAN. I did a cursory projection and, even if we—and when I say "we" I mean nurse anesthetists—and anesthesiologists continue to put out the number of graduates we have today, we will never meet the demands of the future, with the elderly population increasing, as well as acuity of patient increasing.

The types of patients that we are seeing are demanding more care, in which we are having more patients in critical care situations.

Senator CHILES. How will increasing the Center for Nursing Research help your cause?

Ms. JORDAN. That will help in regard to research activities for nurse anesthetists in regards to nurse anesthesia, specifically, but also with the geriatric patient.

We really don't know that much about geriatrics, and we need to increase that knowledge base, especially in anesthesia.

Senator CHILES. But you think a lot of this fee thing has something to do with the way Medicare and Medicaid provide their fees?

Ms. JORDAN. I do believe it has some impact. Yes.

Senator CHILES. Well, we thank you very much for your appearance here today.

Ms. JORDAN. Thank you, Mr. Chairman.

STATEMENT OF LINDA GILMAN, PH.D., PRESIDENT, NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES AND PRACTITIONERS

Senator CHILES. We will hear from Linda Gilman, president of the National Association of Pediatric Nurse Associates and Practitioners.

Dr. GILMAN. Good morning.

Thank you for the opportunity of being here.

I am pleased to submit my written testimony for the record.

I am going to divert from what is on the testimony and——

Senator CHILES. If you would, pull your microphone up just a little bit.

Dr. GILMAN. OK. How's that?

Senator CHILES. Thank you.

Dr. GILMAN. I am Linda Gilman, and I do represent the pediatric nursing specialty organization. I am here to speak to the refunding of the Nurse Training Act and the National Center for Nursing Research.

Pediatric nurse practitioners are currently functioning in what I call more nontraditional roles than they had been over the last 15 years. They are basically organizing and providing care and educating parents to give care in homes for the technology dependent child. This is a new area for us. But it has opened up, and this is another reason why we really need more funding for nurse practitioner programs.

Currently, there is a demand for availability of nurse practitioners that is at about 2 to 1. It outstrips the numbers that are being prepared.

Nurse practitioners do serve a population of underserved individuals from geriatrics to the special needs child.

I urge funding at least at the current authorization level, which is $12 million, and would encourage you to consider going up perhaps to $19 million for the nurse practitioner programs.

In looking at the National Center for Nursing Research, I feel this is vital to our continued professional growth, since research is the proven remedy for innovative nursing interventions and more cost-effective methods for nursing care.

We do support appropriations at $32 million.

We encourage you to support the nurse education and the Center for Nursing Research because we feel this is vital to the continued provision of quality nursing care.

PREPARED STATEMENT

Do you have any questions?

I have submitted my written testimony and you can read it.

[The statement follows:]

STATEMENT OF LINDA GILMAN

I am Linda Gilman, President of the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP) and I thank you for the opportunity to present testimony on their behalf. I am a certified pediatric nurse practitioner, a member of NAPNAP for many years, faculty to Indiana University, School of Nursing Graduate program and I also practice in a pediatric well child ambulatory health clinic.

Last year, we testified about a nursing shortage and since this time, the problem has exacerbated. While the effect has not been fully realized in the pediatric nurse practitioner field, we are concerned.

Nursing schools across the country are facing shrinking numbers of students. Nurse to patient ratios are alarming. Hospitals, clinics, nursing homes, and rural areas are desperately searching for qualified nurses to fill the empty slots. The demand is great yet the supply is minishing.

We are an advanced nursing specialty that was created twenty years ago to fill a void in the pediatric health care spectrum. PNP's deliver primary care like well baby check-ups, providing preventative health care that includes immunizations, health education and counseling. We can treat children with acute illneses or minor trauma within our scope of practice.

In order to be a PNP, one must be a Registered Nurse before continuing her advanced education as a PNP. If there are not enough RN's in the total pool of recruitees, then it will be much more difficult for us to recruit other nurses into our field.

Today, there are 40 PNP programs in the country. Of the 40, three are certificate programs and the rest are at the graduate or Master's level. Of the 3 certificate programs, two are hospital based, and one is a military U.S. Air Force program.

According to the Division of Nursing at the Department of Health and Human Services, 13 PNP programs were funded under Title VIII of the Public Health Service Act. The average award was $185,000 per year. During the past year one program in Missouri had to shut down because there was not enough federal funding to support its continuations. As a result, we are unable to offer any PNP programs in that area --an area where PNP's are utilized greatly.

Mr. Chairman, you and your colleagues in Congress have heard similar stories and read the reports of the nursing shortage over the last years.

Unfortunately, the stories get worse. We appreciate your past support in helping to alleviate the problems. And, on behalf of the members of NAPNAP representing over 2,800 pediatric nurse practitioners in the country we urge you to continue your work by supporting the continued funding for the Nurse Education Amendments at last year's authorization level. Recognizing that the authorization of the nurse education programs may not be in sync with the Appropriations process, we specifically request that this Committee fund the nurse practitioner programs at least at last year's authorization level of $12 million. We would hope that when the Nurse Education Act is reauthorized and passed into law, that this Committee would also consider funding those programs at the revised levels.

The continued funding of the Nurse Education Amendments is a necessity to help offset the shortage. These programs provide an opportunity for students of nursing to enhance their nursing education. The amendments have proven vital in the preparation of nursing specialists like pediatric nurse practitioners.

The Nurse Education Amendments are vitally needed to prepare nurses for our rapidly changing health care setting also. Our patients are sicker and are requiring more care. Health administration and management is more complex and computer knowledge is quickly becoming a prerequisite for employment. The Nurse Education programd are able to prepare nurses to work in the changing environment. Today, we have PNP's working in rural health care settings, community health centers, in hospices, home health care settings and in day care centers. Our emphasis is in promoting healthy babies, healthy children and healthy parents. When given the chance, we have proven that these efforts in health prevention health promotion and wellness work.

Without your continued support of the Amendments, the word from Congress will seem to be that nurses are no longer required in our health care system. We think you feel differently.

The National Center for Nursing Research (NCNR) is celebrating its 2nd anniversary this spring. As an original supporter of the conception of the NCNR, we continue to be excited about the range of possibilities that the NCNR offers to nursing and health care. Research is the proven remedy for innovative techniques and finding quicker, more cost effective methods of health treatment. The NCNR provides grant money for research and training opportunities for nurses.

Examples of current research projects that are of interest to our specialty are:

- research that could identify potential cardiovascular risk factors in children;
- research that will help neonatal intensive care nurses intervene with the parents of those children and help them to better deal with their stress;
- research that will help us retain nurses in intensive care units like pediatric and neonatal care units where the nursing shortage seems to be the most severe.

It is essential that the NCNR be given the opportunity to strengthen the foothold its begun in the research community and to continue on the path it has barely explored. **We support and urge your consideration of an appropriation of $32 million.**

Our health care system is in transition. Long term care concerns, catastrophic health assistance, insurance liability, high infant mortality rates, and AIDS, are issues with which we have all become familiar. We need to prepare for these concerns today instead of reacting to the next crisis tomorrow. We need to encourage and demonstrate to our youth-- both the men and the women -- that the prevention of disease, the caring and treating of the ill and the injured is a worthwhile and satisfying career path. We need to stand up for the nurses and nurse practitioners already in the field who provide the care and assistance that is so desperately needed. We need a promise to society that when our parents and our kids are sick that there will be professional, compassionate, highly educated individuals available to care for them. Your support of the Nurse Education Amendments and the National Center for Nursing Research will assist in sending and translating this message.

Mr. Chairman, the National Association of Pediatric Nurse Associates and Practitioners thanks you for your past support and the opportunity to appear before you today. I would be happy to answer any additional questions.

Senator **Chiles**. Well, we again think the work that you all do, the pediatric work, is tremendously important work. I am distressed to see that there are these shortages.

Dr. **Gilman**. Yes; there are shortages.

Senator **Chiles**. We have seen a school close down in Missouri, and we will certainly try to give this our consideration.

Dr. **Gilman**. Thank you very much.

Senator **Chiles**. We thank you.

SUBCOMMITTEE RECESS

Now the subcommittee will stand in recess until 9:30 tomorrow morning, when we will continue our public witness hearings.

[Whereupon, at 11:36 a.m., Wednesday, May 18, the subcommittee was recessed, to reconvene at 9:30 a.m., Thursday, May 19.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1989

THURSDAY, MAY 19, 1988

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:30 a.m., in room SD-192, Dirksen Senate Office Building, Hon. Dale Bumpers presiding.

Present: Senators Bumpers, Weicker, and Domenici.

NONDEPARTMENTAL WITNESSES

Senator **WEICKER** [presiding]. Good morning. The subcommittee will come to order.

Today we begin our third session of public witnesses, with testimony focusing on the programs funded by the Subcommittee on Labor, HHS.

During the several sessions, the subcommittee will hear testimony from approximately 225 witnesses, the highest number yet to be heard by the subcommittee in a single year. Because of the large number of witnesses, we must request that each witness keep their oral testimony brief. You should be assured that your full statement will be included in the printed record.

In order to help us stay on schedule, we are going to use the red light system. When the red light goes on, your 3 minutes have expried, and it is as embarrassing to me as it will be to you, to bring down the gavel at that time, but that is exactly what will happen.

We will need to ask each of you to conclude your remarks when the red light goes on so that each witness will have a fair and equal opportunity to be heard.

STATEMENT OF CHAPIN E. WILSON, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Senator **WEICKER**. Our first witness this morning is Chapin Wilson of the American Federation of Government Employees. I certainly hope my good friend Ken Blaylock is in good shape.

Mr. **WILSON**. He is.

Senator **WEICKER**. That is good. Well, you send him my best, and please proceed, Mr. Wilson.

Mr. **WILSON**. Good morning, Senator.

Thank you very much.

It is a pleasure for us again to be here before the committee.

We represent the American Federation of Government Employees, approximately 700,000 workers nationwide, 60,000 of whom work for the Social Security Administration. We are here again today to bring to you more bad news about the constant and accelerating deterioration in service delivery in Social Security. A recent GAO report which Senator Chiles and the Commissioner testified here which has now been delivered to this committee, indicates that the error rate is up 37 percent. Things are getting much worse. The Commissioner, if she has her way in her budget request, there will be this year a 10-percent reduction in work-years in Social Security, 7,370 work-years this year alone.

I have just returned from kind of a tour of several parts of the country, a week in California 15 offices in the San Joaquin Valley, throughout all of Michigan, 15 offices in the State of Michigan, and yesterday I was in Boston, and the day before, six offices there.

Unequivocally, the employees confirm what the managers are saying in their survey, which was the Commissioner's own survey, that things are getting much worse. Eighty percent of them say that things are worse now than they were a year ago. These are the field office managers, where the people that all of you are here to represent have to go to get services. Things are much, much worse.

We would like and request from you again this year, as you have provided in previous years, a statutory staffing level, and we will be working very hard this year, and there are some positive signs there, with the House to see that in conference they would go along with the Senate this year.

So we would ask you again to please provide for a statutory staffing floor, and we will try to do our side on the House side.

PREPARED STATEMENT

We are here representing and speaking on behalf of not only the employees, but certainly also the folks that we want to be able to serve that increasingly we are unable to serve, and those are the claimants and the beneficiaries.

Thank you, Senator.

Senator Weicker. Thank you very much, Mr. Wilson. I appreciate your testimony. It will be included in the record in its entirety.

Mr. Wilson. Thank you.

[The statement follows:]

STATEMENT OF KENNETH T. BLAYLOCK, NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

My name is Kenneth T. Blaylock. I am the National President of the American Federation of Government Employees (AFGE), AFL-CIO. AFGE represents 700,000 government employees, including almost 60,000 workers in the Social Security Administration (SSA).

I appreciate the value of the Chairman's time and the Committee's time so I will keep both my written and oral statement brief and to the point.

Our current position is the same as it has been in our previous testimony before this Committee. The SSA is seriously malfunctioning. SSA workers and managers are under increasing stress from intolerable and unnecessary pressure; yet the SSA is asking for 7,370 fewer work years than authorized by this Committee for FY 1988. SSA workers cannot sustain cuts of this magnitude and continue to hold the system together. They have told us in eloquent sworn affidavits (that we have made available to this Committee) and in surveys that we have conducted that job stress is at an all time high. They cannot any longer do "more with less" or "work smarter" - two phrases which the Commissioner is so fond of using. They tell us in powerful terms that they can no longer fulfill the agency's historic mission adequately.

Other warning signals we have include GAO report after GAO report which show that the disasters are mounting:

- $58.5 billion of workers' earnings are unposted from 1978-1984 (GAO/HRD-87-52).
- one in six payments to current beneficiaries is incorrect (GAO/HRD-88-10).
- The payment error rate is twice as high as the rate reported by SSA (GAO/HRD-88-10).
- Systems modernization is grossly over budget and behind schedule with respect to software (various GAO reports).

- Recently GAO has reported an alarming finding that there has been a dramatic increase in the error rate (forthcoming). This increase can be directly attributed to the staffing cuts. Systems modernization will not bail out the agency. 2.5, a major software product dealing with post-entitlement, was to be put into effect in March. However, it has been indefinitely delayed. As more and more terminals come on-line in the field offices and payment centers, the current system will become more and more "stressed." Less and less time will be spent on quality as more and more time is spent on processing initial claims, the indicator the agency has thrown all its energy into.
- Telephone service is unacceptable, yet the agency plans to go to a nationwide "800" number. But, it can't manage the system it has.

The managers' survey, conducted by Commissioner Hardy, which we have made available to you and your Committee, paints a bleak picture indeed (I note that you probably would never had learned of the survey results if we had not made them known to you.) I will mention just a few statistics from the survey:

- 82.6% of field office managers say that SSA is a worse place to work than a year ago;
- 64.9% believe that it will be worse still another year from now. (We suspect this number would be higher if they knew the Commission was asking for 7,370 fewer work years for FY 1989);
- 76.8% of the managers are not comfortable with the downsizing process;
- Only 27% of the managers feel that their employees are satisfied with their job;
- Only 33.5% of field office managers report high morale;
- Only 26% of managers report their employees' morale as high or extremely high.

The listing above does not constitute all of the danger signals. Former Acting Commissioner McSteen has testified that the staffing reduction should stop and that the downsizing isn't working as planned. The National Committee to Preserve Social Security and Medicare has filed a lawsuit against SSA and the HHS based on the agency's failure and seeming unwillingness to address the earnings posting debacle.

The agency attempts to defend itself with an Inspector General's client satisfaction survey which does little more than measure how nicely the public is treated by SSA employees.

These SSA employees know their job. They believe in the service they provide. So, of course, they are understanding, sympathetic, and courteous. They are professional federal employees in spite of the mismanagement of their agency.

The GAO "service numbers" so often cited by SSA are merely and purely the agency's own data passed through, but not validated, by the GAO.

Mr. Chairman, we call on you to help save this vital program and not allow the American public to lose its faith in this program that until recently has been so successful. A staffing floor, statutorily mandated at last year's work year level of 73,675 would be a start.

Also as SSA moves forward on installing its new computer terminals it is important that the employees health and safety be protected. We request that the Committee earmark sufficient funds so that appropriate ergonomic furniture be installed simultaneously with the new computer terminals.

Finally, a top to bottom review of SSA policies and practices should be conducted with the mandate to provide recommendations to Congress and the Committee.

We also want to take this opportunity to go on record against the expansion of the Commissioned Corps Officers of the Public Health Service under the Office of the Assistant Secretary for Health. The Commissioned Corps was formed about one century ago as a quasi-military organization to provide an expert, mobile, flexible, workforce to overcome epidemics and non-military national disasters. By and large the expansion of localized health care treatment and advances in technology have eliminated the Corps original justification.

Because the Corps is a uniformed service, they are eligible for all the standard military benefits including; 20-year retirement, full-paid health care and higher pay than their civilian counterparts (See GAO/NSIAD-88-67BR). Yet, they basically perform the same duties as their civilian counterparts.

Therefore, we strongly urge against the expansion of the Corps and request a full study on the justification for their continued existence in their current form.

Thank you.

STATEMENT OF LOUIS VAN DE BEEK, M.D., DIRECTOR OF MEDICAL AFFAIRS, PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH

Senator WEICKER. The next witness is Dr. Louis van de Beek, of the Philadelphia Department of Public Health.

Please have a seat and proceed.

Dr. VAN DE BEEK. Thank you, Senator.

I want to thank you for inviting us to testify today.

I am here representing our mayor, Mayor Wilson Goode of Philadelphia, to discuss with you the incredible necessity of AIDS funding for Philadelphia and all of our urban areas.

The incredible severity of the epidemic, I think you are well aware, over 60,000 people in the United States are already diagnosed with AIDS. Over one-half of those people are dead—is at once both overwhelming and challenging. It is overwhelming because none of us can really bring ourselves to deal with the fact that thousands upon thousands of young people who are just on the verge of beginning their own lives are being stricken down by a fatal killer.

It is also overwhelming because of the incredibly grave nature of the epidemic. Even as we sit here it is widely believed that at least 2 million Americans are infected with this virus. In fact, Senator, if we could stop this epidemic today, if somehow we could stop the epidemic in its tracks on this day, there is every reason to believe that by the end of this century 1 million Americans will have died of AIDS.

The challenge of the AIDS epidemic is the greatest we have ever faced in the field of public health. Never before for the public health sector, and for myself as a public health physician, has the opportunity so clearly existed to save the lives of millions of Americans, but never before has the saving of lives relied so heavily upon the abilities of you as our leaders to develop the courage to stop doing business as usual when it comes to this epidemic.

Because the AIDS virus is spread through behaviors which are extremely personal but almost always consensual, our only hope to arrest the spread of the virus is to present appropriate educational messages to target populations in a manner that is going to enable those people to understand the messages and to incorporate changes in their behaviors which can save their lives. And that is something we are simply not used to doing.

I would like to put aside my written remarks for a second, Senator, and share with you a very personal story about a patient known to me because I think this might bring the AIDS epidemic home to some of the people here in a way that these written comments could not possibly do.

A young lady who here I will refer to as Tracy King, basically a 14-year-old girl in a section of Philadelphia known as Kensington, a poor white neighborhood bordering a largely Latino neighborhood, and bordering the largely black ghettoes of north Philadelphia, came to be a patient of mine and came to speak to me about her dreams and what she sought in life. Earlier this year she came to me seeking contraception because in the midst of her poverty, in the midst of her broken family she had sought the love of a male companion, and as we know, all too often, young women in America seek contraception after they have initiated sex, not before.

Because this was indeed the case with Tracy and because I was so used to seeing this all too familiar story, we did a pregnancy test first, and indeed, it came back positive. Because I had known the family, I asked Tracy if she could share this with her mother, and if we could discuss it with the family unit.

Well, the mother called me, and it was then that the nightmare began, Senator. To make a long story short, the mother had been infected by the AIDS virus by sharing needles with Tracy's boyfriend. Although Tracy had managed to escape drug abuse at this young point in her life, her mother was infected, there was every reason to believe the daughter was infected—after all, she was pregnant—and there was every reason to believe that that fetus within her was infected.

Our Medicaid system did not provide for abortion for Tracy, and we desperately sought support for her in local women's agencies and local provider agencies and to get the money for her any way we could to help her. Last Thursday, sir, during a meeting in my office, it became all too obvious that Tracy had found her own solution.

I am sorry, I get a little emotional at this point. During a meeting, which is what we do so often in my job, we have so many meetings, it became my job to talk this girl through the most terrifying experience of her life because, unable to get any help anywhere, and knowing that the baby within her faced a certain, near certain death from AIDS, Tracy took it upon herself to induce her own labor by means of a coat hanger abortion, which we know have been all too common in the past history of this country.

To make a long story short, we talked her through it, and she felt herself bleeding to death, managed to get her to an emergency room where indeed society could respond by completing that procedure, that D&C, because at that point, had we not helped her, she would have bled to death, and now this girl—she is now 15 years old—faced the spectre of going home to a mother who is seeing her own life creep away from her, knowing she is infected, beginning to develop symptoms. The boyfriend, as is so often the case, is no longer on the scene.

And Tracy herself has to deal with the fact that she faces a very, very likely death from AIDS.

In my testimony which I know you have written copies of, what we are specifically asking for is that bureaucracy not be allowed to slow up the funding of AIDS programs while more people die. we are calling on the Federal Government to introduce a mandatory 30-day turnaround time for the review of proposals for AIDS funding at all levels of government.

In our own State, the State legislature, because it could not coordinate the passage of funds which were allocated to Philadelphia programs by the Federal Government, indeed wasted time while more people died in Philadelphia.

PREPARED STATEMENT

Senator, I know that time is short and I will make this brief but I want to share with you my sense of the AIDS epidemic and what the AIDS epidemic is in Philadelphia.

[The statement follows:]

STATEMENT OF LOUIS van de BEEK

I want to thank the distinguished members of Congress present for inviting the City of Philadelphia to present testimony today concerning the critical neccesity of support for AIDs related activities in our cities. The incredible severity of this epidemic--over 60,000 people already diagnosed with AIDS, with over half of them dead--is at once both overwhelming and challenging. It is overwhelming because none of us can really bring ourselves to deal with the fact that thousands upon thousands of young Americans, just on the verge of beginning to make their own very special contributions to society, are being struck down with this horrible, debilitating disease. It is also overwhelming because of the very grave personal nature of the epidemic: even as we sit here, it is widely believed that up to two million people in this country already harbor this infection, and half of those people will likely die this most cruel of deaths. It is overwhelming because those of us charged with protecting the public health must admit to ourselves that, regardless of what occurs here today, we will experience the death of thousands and thousands more, already infected by the human immunodeficiency virus. Indeed, if we were somehow able to stop the transmission of this virus at once, there is every reason to believe that by the end of this century one million Americans will still have died of AIDS.

The challenge of the AIDS epidemic is the greatest we have ever faced in the field of public health. Never before has the opportunity so clearly existed to save the lives of millions of our citizens. Never before has the saving of lives relied so heavily upon the abilities of our leaders to develop the courage which will make it possible to fund a comprehensive program, the results of which will not become evident for years into the future. Because the AIDS virus is spread through behaviors which are extremely personal but almost always consentual, our only hope to arrest the spread of the virus is to present appropriate educational messages to target populations in a manner that will enable those individuals to both understand the messages and incorporate those changes in their behavior. Such an effort can result in the saving of countless lives.

This is not something we are used to doing. Even as the surgeon general makes a valiant effort to educate the American population about the ill effects of smoking, he must go to work every day knowing that his own ability to educate is dwarfed by the budgets of tobacco companies seeking to promote the use of their product. Yes, we are all too used to fighting amongst ourselves, rather than addressing the common enemy. This epidemic challenges us in a way that we have never been challenged before; all segments of our society must unite in a dynamic, no holds barred approach to stopping the spread of this virus. To do any less means that the next generation will experience AIDS as the major cause of death amongst young people in our country. This year, it is likely that more young Black males will die from AIDS in the city of Philadelphia than from any other single cause.

In Philadelphia, the face of the AIDS epidemic is changing. Back in the early 1980s, AIDS was a disease of the Center City Gay White males, almost universally employed, highly insured, and able to access care in a manner that kept the epidemic [illegible] our friends, but the misguided belief that somehow this plague would restrict its devastation to those people who are all too used to being considered outcasts of society prevented any cooordinated response to the problem. Those of us in the community, fighting for change, were all too often perplexed by what seemed to be an incredible degree of bureaucratic insensitivity to this killer disease. Ironically, our greatest ally in convincing America that a comprehensive response to this epidemic is needed has been the virus itself. Because the human immunodeficiency virus, having already decimated segments of the Gay community, has barely begun its work.

Currently, the epidemic seems most prominent amongst the IV drug using community. In March, thirty eight percent of cases of AIDS confirmed in Philadelphia involved intravenous drug use as a risk factor. In addition, the epidemic is just beginning to reach those individuals who, often totally without their knowledge, have been the heterosexual partners of people who have used intravenous drugs. Because it will take, on average, seven years for an individual to develop symptoms after having been infected with the virus, and because the behaviors involved in transmitting the virus are both repetitive and consensual, it is likely that anyone who is infected will continue to participate in either sex or the sharing of needles, thereby infecting countless others. The simple fact of the matter is that, of the perhaps two million infected with this virus, only a small percentage have any idea that they are infected. And, if we look at the surrogate markers of syphilis and teenage pregnancy, it quickly becomes evident that the overall incidence of risk taking behavior has never been higher. In Philadelphia, there was a 115 percent increase in the incidence in reported syphilis between 1985 and 1987. The age specific teenage birth rates, both amongst Blacks, Latinos, and Whites, are the highest they have been in fifteen years. So, even as we are well aware that an increasing porportion of our population is becoming infected with a virus that can kill them, it is also evident that these individuals are doing everything they can to infect others; namely, having unprotected intercourse.

There is no question that we have missed many opportunities in this epidemic. While I and others like me have sat here in Washington, trying to convince the federal government of the urgency of this epidemic, countless others have been on the front line in the communities where high risk behavior is occuring, trying to convince their family, their friends, and people they don't even know that we must stop killing ourselves and each other. But what have we done to support those efforts?

The initial issue clearly was funding. Until recently there have effectively been no dollars for community-based organizations fighting this epidemic at the local level. Fortunately, the situation has improved somewhat. However, those same gallant fighters in the AIDS epidemic are now plagued by a far more cruel adversary, because this new adversary is one which defies our best efforts to combat it; bureaucracy.

Yes, it is bureaucracy that is now the major enemy of those striving to fight this epidemic. It is bureaucracy which prevents us from learning of grant awards until well after the funding period has begun. It is bureaucracy which demands that, even as we begin fledgling efforts to provide education, counseling and testing to people at risk, that we closed those very sites because our applications for support have not even been reviewed. It is bureaucracy that allowed the Pennsylvania State Legislature to permit deadlines to pass while people died, only because that legislature could not coordinate the appropriation of federal dollars to existing programs. It is bureaucracy, which, through a process that has never been explained to us in Philadelphia, decided that somehow the City of Philadelphia simply could not have access to money for seroprevalence studies. Somehow, Philadelphia, which ranks tenth amongst cities in number of cases confirmed, could not be included on the list of thirty cities where such funding would be provided.

If the issue were a political one, I would rally political support. If the issue were a medical one, I would plead for the support of our medical community. When the issue is a community based one, we must work closely with those people that are known to the community. However, what are we to do when the bureaucracy fails to repond? This has been the case all too often in this epidemic, and that is the basis of my plea today that the Federal Government of the United States take the pledge that our efforts in combating this plague will not be business as usual.

Today I come to you to call for direct funding of localities by the federal government for AIDS related activities. Certainly, there is no lack of bureaucracy at the centralized federal level; indeed, the city government of Philadelphia also has processes of which must be followed in awarding contracts and dispensing funds. However, when the lives of so many people are clearly at stake, and when there can be no question that delays in allocation of funding will result in more people dying, we must all do our part to make sure that those bureaucratic processes do not become bureaucratic killers. Direct support for local health departments will go far towards addressing this problem. In addition, expedited review of all proposals submitted in the area of AIDS research, community based education activities, and other applications for AIDS funding must be mandated at all levels of the federal bureaucracy.

I propose today that the Congress adopt a thirty day mandatory turnaround time on all applications for funding for AIDS related programs. Once funds are allocated, they must be made available on an expedited basis. Local health departments, because they are closest to the problem, are in an optimal position to coordinate disbursement of funds. In some cases, I do not doubt that even this porposed streamlined approach may be an inadequate response to the current plague of bureaucratic delays. Indeed, direct funding of organizations in the community may be the appropriate technique in areas where local authorities prove themselves to be more a barrier than a facilitator in this process.

In Philadelphia, I am proud to tell you that our leaders have begun to take the AIDS crisis seriously. The administration now recognizes that "business as usual" is not only an inadequate response - it is a deadly one. Our city and our nation have been invaded by a foe that we simply lack the resources to fight. One critical resource of government is its credibility. And the credibility of you and I as advocates for the health of all of our citizens has never been more at stake.I can only hope that we will all find the courage within us to cast aside our preexisting biases and misguided faith in bureaucratic structures and instead seek to fight this epidemic as we would a military invasion of our land. We must act with that degree of urgency if we are to save the lives of our citizens, our families and ourselves. Your role as the leaders of this nation dictates that you must make a personal committment to fighting AIDS, and my responsibility as a public health physician is to demand of you no less.

Senator **Weicker**. Dr. van de Beek, first of all, let me say this, that I am deeply touched by your story, and I have got to be fair to the other witnesses. I have let you go over by just about double here on your testimony. That red light has been on for 3 minutes now, so I am afraid I am going to have to ask that the rest of your comments be included in the record.

Let me assure you that I concur with all that you say. As you know, this has been a No. 1 priority for this particular Senator in all of its respects, research, initiating the program, I might add, for the various cities. So it is not that your words are falling on deaf ears at all. I am glad to have this as a matter for the record, and believe me, I think it will have an impact upon my colleagues but I also have to be fair to the other witnesses.

Dr. **van de Beek**. Thank you.

May I leave these written copies as well?

Senator **Weicker**. You absolutely can, and again, I want to thank you for taking the time to come here, and I am just delighted that that world out there consists of people like yourself who have both the compassion and the commensurate expertise to try and help in what we all admit is a terrifying thing.

Thank you.

Dr. **van de Beek**. Thank you, Senator.

STATEMENT OF AL GUIDA, POLICY ANALYST, AMERICAN ASSOCIATION OF UNIVERSITY AFFILIATED PROGRAMS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Senator **Weicker**. Dr. Ansley Bacon, president of the American Association of University Affiliated Programs for Persons With Developmental Disabilities.

Mr. **Guida**. Mr. Chairman, good morning. Dr. Bacon was not able to make it from New York today. I will try to summarize the testimony very briefly.

The Congress, Senator Weicker, made very significant changes——

Senator **Weicker**. Could you identify yourself, please?

Mr. **Guida**. Oh, my name is Al Guida. I am with the American Association of University Affiliated Programs. I am their policy analyst.

The Congress made significant changes to the Developmental Disabilities Act last year, and we are just here today to try to describe some of those changes.

The university affiliated programs [UAP] are training programs. We train physicians and allied health professionals in treatment methods for the developmentally disabled. There is one in Connecticut.

The three significant personnel preparation initiatives, Mr. Chairman, occurred in three areas: paraprofessional training, services training for professionals for the elderly developmentally disabled, and the early intervention program. I would like to go through those very briefly.

The Congress, specifically, the Senate Subcommittee on the Handicapped, responded to significant data on the lack of trained paraprofessionals for community programs. Dr. Brunix from the University of Minnesota produced data which indicated that on a nationwide basis today, we need about 50,000 trained paraprofessionals, and I am referring to direct care workers, job coaches, folks who work in group homes, who provide the day-to-day services to persons with developmental disabilities.

The data indicates that by the year 2000, we would need 75,000 trained paraprofessionals to work in community programs and to sustain persons with developmental disabilities in the community. The Congress provided the UAP's with a specific mandate to train paraprofessionals in conjunction with junior colleges and community colleges across the country.

A similar specific training mandate was included for the yearly intervention program, Senator. You were responsible in the Education of the Handicapped Act for developing a dramatic program for early intervention and the provision of multidisciplinary services to infants and toddlers between birth and 2 years old.

Where we have had difficulty, Senator, however, is in the training of allied health professionals, occupational therapists, physical therapists, speech pathologists, to actually provide that training or actually to provide those services at the State level.

The Congress was responding to data which indicated in a State survey that was conducted after the legislation was passed, 96.2 percent reported that they had substantial shortages of allied health professionals in the disciplines I just mentioned,, and a number of others, and that 82 percent reported that by the year 1989, the first year of implementation, they would still have substantial deficits in each of those areas.

PREPARED STATEMENT

Mr. Chairman, I see my time is up, and I will conclude my remarks.

Thank you, sir.

Senator WEICKER. Thank you very much for your testimony. Your statement in its entirety will be placed in the record.

[The statement follows:]

STATEMENT OF ANSLEY BACON, PH.D., PRESIDENT, AMERICAN ASSOCIATION OF UNIVERSITY AFFILIATED PROGRAMS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

I am Dr. Andy Bacon, Director of the Mental Retardation Institute in Vallaha, New York, which is affiliated with the Westchester County Medical Center and New York Medical College. I am also this year's president of the American Association of University Affiliated Programs (AAUAP).

While my primary purpose in being here today is to emphasize the importance of adequate and appropriate training for personnel who provide services to persons with developmental disabilities, I also wish to update you on recent congressional and federal agency activity in this critical area.

Developmental Disabilities Act:

For example, in the Developmental Disabilities Assistance and Bill of Rights Act Amendments of 1987 that passed last year, Congress authorized significant new training intiatives for the forty three (43) federally funded University Affiliated Programs known as UAPS. The original 1975 legislation that created these programs defines three statutory mandates encompassing personnel preparation, exemplary service provision and technical assistance to community-based organizations.

The DD Act has historically embodied Congress' commitment to insuring that persons with developmental disabilities receive the care, treatment and other services necessary to make community living a reality. Consequently, it is not surprising that the authorization committees in both houses recognized the need to train the workers who have the most day-to-day contact with handicapped persons -- paraprofessionals. These individuals including case-workers, psychiatric technicians, rehabilitation assistants, house parents, job coaches and group home workers constitute the foundation of the community-based residential services system. The new DD Act attempts to tackle the enormous challenge of providing these workers with basic training and badly needed skills. And make no mistake, the task is staggering. Recent estimates indicate that the present demand for paraprofessionals to perform basic services in small, community residential settings is 50,000 nationwide. By the year 2000, that estimate jumps to over 75,000 hands on staff necessary to perform essential daily tasks. AAUAP believes that the paraprofessional training initiative is the first step in a broarder effort involving other federally funded programs, state agencies, local entities, and community and junior colleges to provide high quality services in less restrictive, better integrated residental environments.

Another area addressed by the new developmental disabilities legislation is the provision of early intervention services. In 1986 Congress, under the Education of the Handicapped Act, created a new early intervention program to assist states in implementing a state-wide, multidisciplinary, and interagency program of early intervention services to handicapped infants and toddlers from birth through two years of age. The program mandates the provision of family training and counseling, care coordination services, physical and occupational therapy, psychological services, and early identification, screening and assessment services. The substantive value of these activities cannot be reasonably disputed since numerous studies have demonstrated that early intervention strengthens prevention, facilitates future community integration, and actually reduces the severity of a child's functional limitations.

However, on a national basis, we lack the qualified allied health professionals needed to competently administer the mandated services. For example, a recent survey of the 50 states reveals that 96.2% report substantial shortages of trained physical therapists, speech-language pathologists, and occupational therapists to work in early intervention programs. In addition, 82.7% of the states expect the shortage to continue through 1989, the first year of implemetation of the birth through two program under EHA. The new DD Act provides UAPs with the specific mandate to furnish the trained allied health professionals necessary to do the job right.

Finally, Congress addressed the specialized personnel preparation needs of the burgeoning elderly developmentally disabled population. The national statistics in this area are truly alarming. Using 1986 data, there are currently 200,000 people over age fifty five (55) with a developmental delay or disability. This population is projected to increase to 589,000 by the year 2020. Indeed, these statistics would imply that, as we approach the 21st century, about 4 out of every 1000 older Americans will face a handicapping condition. The new legislation begins to address the training implications of these numbers by authorizing cooperative programs between UAPs and university-based gerontological training programs across the country.

Chairman Chiles, your support and that of Sen. Tom Harkin during the House-Senate conference on the FY 1988 Continuing Resolution permitted these special training intiatives to be funded. I want to take this opportunity to personally thank you and express the appreciation of my entire national association, which represents fifty-three (53) universities in 38 states, for your strong leadership in improving both the quantity and quality of services to persons with developmental disabilties. In view of the UAP network's commitment to information sharing and coordinating limited resources, we strongly believe that the investment Congress has made in personnel preparation through the

Developmental Disabilities Act will have a significant national impact. While the realities of the federal budget deficit may make it difficult to actually increase spending on the training initiatives I have just described, AAUAP strongly encourages you to support the existing level of funding for these programs.

Maternal and Child Health Block Grant:

In addition, Mr. Chairman, the $30 million increase which was provided for the Maternal and Child Health Block Grant permitted the funding of a case management training program for the UAP network at the initiative of the Bureau of Maternal and Child Health. The primary focus of these projects will be to increase the awareness and understanding among health and service delivery decision-makers at the state level regarding the basic prinicples of effective case management and the exisiting models of such care. We hope to impact a wide array of service providers including educational and vocational rehabilitation programs, state Title V agenices, and the early intervention programs referenced earlier under the Education of the Handicapped Act. The primary purpose of care coordination is to insure that children have access to needed services. The Bureau's initiative directly addresses the critical role that personnel preparation plays in the cost-effective delivery of care.

As you know, the President recently recommended full funding for the Maternal and Child Health Block Grant at $561 million for FY 1989. Moreover, the House Budget Resolution exempted the program from the 1% reduction for all domestic discretionary health spending. AAUAP strongly supports this increase and requests that you approve it, not only to further the training programs we represent but -- more importantly -- to fight infant mortality, which is the principle focus of the the Block Grant.

Mental Retardation Research Centers:

Finally, Mr. Chairman, I would like to conclude my testimony with a brief discussion of the fiscal plight facing the

Mental Retardation Research Centers (or MRRCs) funded through the National Institute of Child Health and Human Development.

We were recently informed that, as a result of the President's proposal to essentially freeze non-AIDS funding for the Institute, an administrative decision had been made to eliminate one of three MRRCs currently seeking renewal of their ongoing research grants. The agency's decision is based upon stark budgetary realities. At the proposed level of $399 million for NICHD as a whole, all forty-four (44) existing research centers would face downward negotiated reductions of 25% or more. Consequently, by eliminating research programs in the reproductive sciences, demographic and behavorial research and mental retardation respectively, the agency hopes to cushion the impact of across the board cuts for the remaining extramural research centers.

At the same time, NICHD officials readily concede the extraordinary quality of the applications from the three Mental Retardation Research Centers up for renewal. Moreover, the elimination of the programs in question will still leave the remaining facilities facing funding reductions of 16% or more.

Chairman Chiles, permitting the elimination of these critical biomedical research programs seems extremely short-sighted. The MRRCs, for example, have contributed signficantly to the actual prevention of mental retardation. Just the discovery of fetal alcohol syndrome and the development of a screening mechanism for PKU --taken alone-- have saved the federal and state governments millions of dollars and improved the lives of thousands of children. In fact, many states now mandate PKU testing at birth. Moreover, the new gene therapy currently being purused by these centers could have prevention implications that will have a major impact on the entire field of developmental disabilities.

In view of this critical research, I hope that the subcommittee will take whatever steps are necessary to prevent the defunding of extramural research centers. The Mental Retardation Research Center Directors have gone on record as accepting some negotiated reductions in order to preserve the integrity of the program. Because of your long history of advocacy for persons with developmental disabilities, Mr. Chairman, I request that you not permit our biomedical research effort in this area to be significantly impaired.

Thank you for taking time out from your busy schedule to listen to me today.

STATEMENT OF ERVIN J. PICHA, PRESIDENT, MARION COUNTY ASSOCIATION FOR RETARDED CITIZENS, INDIANAPOLIS, IN; ON BEHALF OF THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

Senator **Weicker**. Mr. Ervin Picha of the National Association of Rehabilitation Facilities.

Mr. **Picha**. Good morning, Mr. Chairman. My name is Ervin J. Picha. I am president of Noble Centers, a comprehensive center serving some 850 children and adults with developmental disabilities in Indianapolis, IN, each day.

I am also here on behalf of the National Association of Rehabilitation Facilities, the trade association for community-based rehabilitation facilities.

For purposes of brevity, I will address three specific issues. Those are the shortage of rehabilitation personnel and the need for training, the need for long-term funding for supported employment programs, and the cost-of-living adjustments for discretionary projects of the Rehabilitation Act.

Rehabilitation facilities continue to be faced with severe personnel shortages, especially occupational and physical therapists, speech language pathologists and audiologists, as well as programs to serve the inservice training needs and retraining of existing staff.

There are two primary sources for the need for training funds, the training authority, title III, section 304 under the Rehabilitation Act, and title VII of the Public Health Services Act, which historically has provided funds for education for these health professionals but has not been funded since 1980.

When title VII is reauthorized this year, NARF requests that an authorization and an appropriation of $20 million be made available for grants for programs for training of rehabilitation professionals, grants to support the graduate education programs and physical therapy, occupational therapy, speech, language, pathology, and audiology, and grants to provide financial assistance to students enrolled in those programs.

As part of the 1986 amendments to the Rehabilitation Act, Congress reinstated the technical assistance program for vocational rehabilitation facilities, and State agencies that had ended in 1978 when language adopted at that time by Congress inadvertently changed the nature and the type of technical assistance allowable.

NARF requests that this subcommittee appropriate the fully authorized level of $35 million for training for rehabilitation professionals in all settings, and that not less than $750,000 be earmarked for technical assistance to facilities and State agencies.

NARF suggests that the program as it was operated prior to 1978 be used as a model.

One of the major new initiatives in the field of rehabilitation that this subcommittee has funded over the past few years has been supported employment. It has now received over $35 million for demonstration projects and for State formula grants. The Rehabilitation Act, however, does not provide for any long-term follow-on services. This funding is expected to come from other local, State, and Federal programs. The title XX social services block grant, for example, could be a good source, but it has not received an increase in funding in more than 6 years, and it is still $200 million below the 1981 level.

The loss of revenue sharing funds has also severely constrained city, county, and State budgets. This subcommittee should examine the funding of supported employment to assure that the follow-on services are available.

Finally, the language should be included in the subcommittee report that would require the Rehabilitation Services Administration to provide cost-of-living adjustments to all discretionary grants and contracts which have not received any increases during the past 2 fiscal years. Some very successful programs such as projects with industry, have not had needed increases for several projects, while new projects have been funded with relatively small amounts of new moneys. This means that older, proven successful projects have lost ground over the past several years.

PREPARED STATEMENT

Mr. Chairman, I see that my time is up. There is additional information and recommended levels of appropriation in our report.

I would be glad to answer any questions you might have.

[The statement follows:]

STATEMENT OF ERVIN J. PICHA

Good afternoon, Mr. Chairman. My name is Ervin J. Picha. I am president of the Marion County Association for Retarded Citizens in Indianapolis. I am here on behalf of the National Association of Rehabilitation Facilities. NARF is the national trade association for community-based rehabilitation facilities.

As you readily can see from our written statement, NARF and its member facilities are engaged in a wide variety of programs which utilize many Federal programs under the jurisdiction of this Subcommittee. For purposes of brevity, I will address three of the issues. They are 1) the shortage of rehabilitation personnel and the need for training , 2) the need for long term funding for supported employment and 3) cost of living adjustments for descretionary projects within the Rehabilitation Act.

Personnel Shortages

Rehabilitation facilities, both medical and vocational, continue to be faced with severe personnel shortages and training programs to provide in-service and retraining for existing staff. There are two primary sources for the needed training funds: the training authority (Title III, Section 304) under the Rehabilitation Act; and Title VII of the Public Health Service Act.

The most severe shortages are of occupational therapists, physical therapists, speech-language pathologists and audiologists. Title VII of the Public Health Service Act historically has provided funds for education of these health professionals. There has not been any funding for allied health, however, since 1980. Title VII is to be reauthorized by Congress this year.

NARF is requesting authorization and appropriation of $20 million for, 1) Grants for programs for the training of rehabilitation professionals, 2)Grants to support the graduate educational programs in physical therapy, occupational therapy, speech-language pathology and audiology and 3) grants to provide financial assistance to students enrolled in these programs. If new authorization is not forthcoming and existing law is extended, NARF recommends specific funding for rehabilitation professionals be made available under Title VII.

As part of the 1986 Amendments to the Rehabilitation Act, Congress reinstated a Technical Assistance Program for vocational rehabilitation facilities and state agencies as part of the training authority in Sec. 304. The program was begun in the early 1960's but ended in 1978 when language adopted at that time by Congress inadvertently changed the nature of the type of technical assistance allowable. The program prior to 1978 received line item appropriation. In 1978, it was funded at $250,000.

NARF requests that this Subcommittee appropriate the fully authorized level of $35 million for training for rehabilitation professional professionals in all settingsand that not less than $750,000 be earmarked for technical assistance to facilities and state agencies. Report language is requested to insure that these funds will be distributed in such a way as to insure easy access to the technical assistance and that it be provided in such a way so to provide the most numbers of consultations as possible for the funds appropriated. NARF suggests that the program as it was operated prior to 1978 be used as a model.

Long Term Funding for Supported Employment

One of the major new initiatives in the field of rehabilitation that this Subcommittee has funded over the past few years has been supported employment. It was first funded as a demonstration project in 1985 and 1986 and it now receives over $35 million for demonstrations and a state formula grant. Supported employment is predicated on the belief that many persons with severe disabilities can work on community competitive work sites if they are given the appropriate follow-along services. Under supported employment it is anticipated that these services will be needed as long as the person is working.

The Rehabilitation Act does not provide any funding for the long term follow along services. This funding is supposed to come from other state and federal programs. It has been very difficult finding these other sources of funds. The Title XX Social Services Block Grants should be a good source but it has not received an increase in funding for more than six years and is still $200 million below its 1981 level. The loss of revenue sharing funding has also severely constrained county , state, and city budgets.

This Subcommittee should examine the funding of supported employment to ensure that the funding for the follow along services is both available and adequate to meet the needs of both the service providers and the individuals sought to be benefitted by this important new program.

It is important for this Subcommittee to realize that supported employment is but one of several programs and employment outcome alternatives that need to be available to meet the individual needs of the disabled person and their family, as appropriate. Choice is a very important part of the rehabilitation process and this committee will hopefully keep this in mind as funds are allocated to the various programs within the Rehabilitation Act and other federal programs such as the Job Training Partnership Act and the Developmental Disabilities Act.

COLA's for Descretionary Porgrams

Finally, language should be included in the Subcommittee report that would require the Rehabilitation Services Administration to provide cost of living adjustments to all descretionary grants and contracts which have not received any increases during the past two fiscal years. Some very successful programs, such as Projects With Industry, have not had needed increases for individual projects while new projects have been funded with the relatively small amount of new funds. This means that older, proven, successful projects have lost ground over the past several years.

Mr. Chairman, there are other programs in the written statement addressing the rehabilitation and employment needs of persons with disabilities. These programs deserve your full attention. NARF has recommended appropriation levels that are not only justified but necessary to even begin to meet the needs of persons with disabilities.

I will be glad to answer any questions or provide any additional information you feel may be helpful.

Recommendations of the National Association of Rehabilitation Facilities For fiscal year 1989 Appropriations (in millions)

	NARF Recommendation
Rehabilitation Act	
state grants	$1,550.00
supported employment	$28.06
NIDRR	$55.00
Training	$35.00
Special Projects	$28.30
PWI	$18.03
Evaluation	$2.11
Independent Living	$46.28
CAP	$8.00
Special Education (PL 94-142)	
state grants	$2,148.66
early intervention	$100.00
pre-school	$274.95
Developmental Disabilities	
state grants	$69.90
special projects	$3.65
P & A	$22.00
UAF	$15.20
Job Training Partnership Act	
Title II-B	$1,881.40
pilots and demos	$40.60
Title XX	$3,000.00
Public Health Act, Title VII	
for allied health professionals	$20.00

Senator WEICKER. Mr. Picha, thank you very much for your testimony.

Please give my best to John Doyle, who served this committee well for many years.

Senator Domenici.

Senator DOMENICI. Thank you very much, Mr. Chairman.

Mr. Picha, when you say you represent the National Association of Rehabilitation Facilities, just quickly tell me what does that mean?

Mr. PICHA. I am a board member and am——

Senator DOMENICI. What is that group?

Mr. PICHA. OK. That group is a national organization made up of some 600 or 700 local community facilities providing rehabilitation services to people with various kinds of handicaps, both—some of the facilities are medically related rehabilitation facilities, and others are vocational facilities.

Senator DOMENICI. It is your testimony, and I am sure it is going to be the testimony of almost everyone that we are going to hear from—the professionals, paraprofessionals, and men and women who work in these fields—that there is an extreme shortage of qualified people to help accomplish our goals, both local and national.

I wonder if you have an opinion as to whether that shortage is because we are not helping them get an education, or is that shortage also somewhat due to the fact that not enough people want to work in this field? Alternatively, with unemployment in many of the States down to 4½ percent, or 3.8 percent, almost zero unemployment in a changing America in my opinion, do you really think if we pushed with some grants for education that we really would fill this gap, or is there something else missing here?

Mr. PICHA. I am not sure that I can answer that in great detail. It is my understanding, though, that many of the university programs have significantly more applicants than they have students, or spaces available in their programs. I think you would have to get that specifically from them.

I guess I can speak from our own personal agency's experience, we have on our staff three positions for speech pathologists. Until about 2 months ago, all three of those positions were vacant and had been vacant for some time because we just were unable to find anyone who was in the area, who had the qualifications that were required to fill those positions.

And as a result, children and adults that were disabled did not have the kind of speech therapy that they needed.

I think there are people out there who are interested in doing this. I think it is a matter of economics for both the students and the universities in that area.

Senator DOMENICI. Mr. Chairman, I just raised the question because I am growing more and more convinced that we are going to be a worker-short society rather than worker-long society.

Mr. PICHA. I think that is right.

Senator DOMENICI. I have great concern that these kinds of jobs are not going to be easily filled in the United States, even if we attempt to give some incentives to people to get the education. I do not have an answer, but it seems obvious to me that if there are three choices of jobs, I somehow have the notion that the service industries of the type we are talking about here may not be either lucrative enough in the American marketplace or may not be desirable enough in terms of the workload and other stresses. We may be fighting an uphill battle, although I certainly believe we ought to do something to encourage as many as possible to get into the field.

I thank you very much, Mr. Chairman.

Senator **Weicker**. Pete, I think the point that Mr. Picha makes also on speech therapists, now, that is something that a lot of people feel sort of, well, that is not important, but let me tell you, I am very lucky as far as my Downs child is concerned in that he does not have any lung deficiencies, does not have any heart deficiencies. You know, he gets along perfectly well physically. He has got pretty good smarts, too. But his biggest problem is being able to communicate, and if you cannot communicate, try the world. It is pretty tough.

Even I have to use—my youngest children that are closer to his age, Mason, who is 9 years of age, the same age as Sonny, and Trey, who is his other brother, 8 years of age, they are translators for me because they are with Sonny under normal circumstances more. But this is his biggest area of need, very frankly.

So I just want people to know that when you say speech therapy and people say, well, it is nice that he is not rounding his O's and doing this, that and the other thing, but it is very basic, the ability to speak so that other people can understand. It is absolutely vital to the community that you serve.

The fact that you have got three vacancies is big trouble for a lot of people.

Mr. **Picha**. That is exactly right.

Senator **Domenici**. Could I ask one other question?

Senator **Weicker**. Sure.

Senator **Domenici**. Following my reasoning and saying that I do not know whether there is an answer, I am reminded that we are growing older as a population. I do not know when that trend will be reversed in the United States, if ever, but that leads me to a conclusion that maybe a lot of our senior citizens who are already retired but clearly have a great deal of energy and capability are very underutilized in the American marketplace.

Do you have any thoughts on this issue? Are senior citizens getting trained and involved in these fields that you are talking about, or are these too technical and too difficult to start over with, in your opinion?

Mr. **Picha**. I think that, you know, again, there are tremendous opportunities for anyone, and certainly people who have retired, who have the skills, could certainly contribute.

I do not see any major move in that direction. We do at our agency, though, just as an example, have a Foster Grandparent Program that involves senior citizens who come back and work in our children's program and are extremely effective in dealing with the children in support of our professional staff, and I think it is a kind of example of what you may be referring to in terms of what the future could hold for us.

Senator **Domenici**. Thank you very much, Mr. Chairman.

Senator **Weicker**. Thank you very much, Senator Domenici. And thank you very much, Mr. Picha.

STATEMENT OF LARRY F. JEWKES, PRESIDENT, NATIONAL REHABILITATION ASSOCIATION

Senator **Weicker**. Larry Jewkes, the president of the National Rehabilitation Association.

Mr. **Jewkes**. My name is Larry Jewkes. I am president of the National Rehabilitation Association.

Mr. Chairman, the Rehabilitation Act of 1973 as amended is one of the most complete and well-balanced pieces of legislation in the human services field to assist Americans with disabilities in their efforts to achieve meaningful employment and self-sufficiency.

In America, approximately 22 million individuals are disabled in such a way as to chronically limit their ability to function. The size of the disabled population is not static but continues to grow through accidents, injuries, illnesses, and birth defects at an estimated rate of 500,000 annually.

Our Nation's investments in this program have returned significant dividends to our Nation's taxpayers, and more importantly, to the persons with disabilities who receive rehabilitation services. Few if any programs funded by the Federal Government consistently return so many benefits, both financial and personal, to all segments of our society.

The Rehabilitation Act amendments of 1986 placed new requirements on the State and Federal rehabilitation programs, requiring each State agency to provide rehabilitation engineering services, independent living services, and the establishment of supported employment service delivery programs in each State.

NRA is recommending the full appropriation level of $1,550,000,000 for the basic State vocational rehabilitation program. This program has served millions of Americans with disabilities and rehabilitated and placed well over 5.5 million people into meaningful, productive jobs.

In speaking to comprehensive services for independent living, NRA supports an investment of $13.5 million for programs under part A, $27.3 million for part B, $5.93 million for part C, and $10 million for part D.

Under part A of the independent living program, State agencies provide services which may enhance the ability of a person with a disability to live independently and function within the community and if appropriate, secure and maintain employment.

Currently under part B, 400,000 individuals are being served by 125 Federal grant recipients who operate over 170 independent living centers.

I would like to skip on to rehabilitation training appropriations and indicate that we recommend $35 million to ensure that adequately skilled personnel are able to keep abreast of new techniques, research findings, information and emerging disabilities.

Under the supported employment area, NRA recommends full funding of $28.6 million. This 1 year old program holds great promise for securing employment for individuals who have not traditionally been eligible for rehabilitation services.

If fully funded, several thousand additional persons with severe disabilities could be served in fiscal year 1989.

As to the projects with industry program, NRA is recommending the full authorization level of $18.3 million to facilitate greater private sector involvement as well as allowing new and innovative projects the opportunity to replicate the proven success of projects with industry.

Mr. Chairman, the Rehabilitation Act and programs authorized signify our society's recognition of its responsibilities to provide citizens with disabilities the opportunity to be full participants in the main stream of life. Thomas Jefferson stated the care of human life and happiness is the first and only object of good government. The Rehabilitation Act of 1973 as amended is representative of President Jefferson's intent.

PREPARED STATEMENT

We thank you, Mr. Chairman, and members of the subcommittee for appropriating funds for the rehabilitation program at the levels we have recommended in this testi-mony.

Thank you.

Senator WEICKER. Larry, thank you very much for your testimony.

[The statement follows:]

STATEMENT OF LARRY F. JEWKES

Mr. Chairman, Members of the Subcommittee, the National Rehabilitation Association is an organization whose purpose is solely to advance rehabilitation for persons with disabilities.

The nearly 17,000 members of the National Rehabilitation Association and its seven divisions -- the Job Placement Division, the National Association Rehabilitation Instructors, the National Association of Rehabilitation Secretaries, the National Rehabilitation Administration Association, the National Association for Independent Living, the National Rehabilitation Counseling Association, and the Vocational Evaluation and Work Adjustment Association -- express our appreciation for giving us the opportunity to present our views.

THE REHABILITATION ACT OF 1973, AS AMENDED

The Rehabilitation Act of 1973, as amended, is one of the most complete and well-balanced pieces of legislation in the human services field. This program of Rehabilitation Services is a cornerstone in the Nation's effort, at the State, Federal, and private sector levels, to assist Americans with disabilities in their efforts to achieve meaningful employment and self-sufficiency.

People with mental and physical disabilities comprise a significant portion of the Nation's population - an estimated 36 million individuals. According to the National Center for Health Statistics, approximately 22 million individuals are disabled in such a way as to chronically limit their ability to function.

The size of the disabled population is not static, but continues to grow -- through accidents, injuries, illnesses, and birth defects -- at an estimated rate of 500,000 annually.

The Rehabilitation Program signifies the Nation's recognition of its responsibility to provide disabled citizens with the opportunity to be a part of the mainstream of life as full participants.

Our Nation's past investments in this program have returned significant dividends to our Nation's taxpayers, and more importantly, to the persons with disabilities who receive rehabilitation services. Few, if any, programs funded by the Federal government consistently return so many benefits, both financial and personal, to all segments of our society.

The Rehabilitation Act Amendments of 1986 place new requirements on the State-Federal Rehabilitation Program. The Rehabilitation Act was amended to (1) require each State Agency to provide Rehabilitation Engineering Services, (2) to assist State Rehabilitation Agencies in the establishment of Supported Employment Service Delivery Programs in each State, and (3) by other changes which, in conjunction with scarce resources, place additional demands on a service delivery system which is currently overburdened, and only, due to the lack of resources, able to provide services to 1 out of every 20 individuals eligible to receive such services.

In light of the fact that 66 percent of individuals with disabilities aged 16 and over report that their disability prevents them from working, and that individuals with disabilities comprise the most underemployed segment of our society, it is vital that State, Federal, and private partners cooperate to provide the assistance necessary for individuals with disabilities to move from income-maintenance and dependency to employment and tax-paying, self-sufficient independence.

REHABILITATION BASIC STATE GRANT

We are recommending an appropriation level of the full authorization amount for the Basic State Vocational Rehabilitation Program, the foundation of the programs authorized in the Rehabilitation Act, as amended, of **$1,550 million**. This proven, finely-tuned direct service program has stood the test of time and has been well managed. Throughout its 68 year existence, this program has served millions of Americans with disabilities and has rehabilitated and placed well over 5.5 million people into meaningful, productive jobs. Comprehensive services are provided by and through State Rehabilitation Agencies, most often through cooperative agreements and contracts with other public, private, and nonprofit community-based organizations and facilities.

A national survey of State Vocational Rehabilitation Agencies provides pertinant information as to the ability of the Rehabilitation Program to respond to the existing needs of people with disabilities. The results conclude:

- In FY 1989, the Federal/State Rehabilitation Program will serve an estimated 930,720 people with mental and physical disabilities.
- Should the Congress only appropriate the President's request of **$1,407.1 million**, there will be NO increase in the number of persons with disabilities served this year.
- Should the Congress appropriate **$1,550 million** in FY 1989, the fully-authorized amount, State Rehabilitation Agencies will be able to serve **an additional 71,000** persons with disabilities, a **7.8 percent increase** over the number served in FY 1988.

Based on this information, the National Rehabilitation Association strongly urges the Congress to approporiate $1,550 million for the Basic State Grant, Section 110 of the Rehabilitation Act, to ensure adequate services for Americans with disabilities in FY 1989.

COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING

NRA recommends an investment of $13.05 million for programs under Part A; $27.3 million for Part B; $5.93 million for Part C; and $10 million for Part D.

Under Part A of the Independent Living Program, State Agencies provide, or arrange for the provision of, any service which may enhance the ability of a person with a disability to live independently and function within the community and, if appropriate, secure and maintain employment.

Currently, under Part B of the Program, 40,000 individuals are being served by 125 Federal Grant recipients who operate over 170 Independent Living Centers.

Under Part C, grants are provided to State Rehabilitation Agencies and to other public or private nonprofit agencies or organizations to assist older persons who are blind to live independently.

The Part D program would provide advocacy services for a potentially large population of persons with disabilities who are eligible for services under the Independent Living Program, but are not eligible under existing protection and advocacy programs or the Client Assistance Program. The President has requested no funds for Part D.

REHABILITATION TRAINING

We are recommending an investment of $35 million for Rehabilitation Training Programs. Rehabilitation Training is a critical element in providing services to Americans with disabilities.

Grants are made to State Rehabilitation Agencies and other public or nonprofit agencies and organizations, including institutions of higher education, to help ensure that adequately skilled personnel are available to provide rehabilitation services to persons with disabilities. Because rehabilitation plans are tailored to each person with a disability, vocational rehabilitation depends upon a well-prepared "qualified" professionals to deliver a wide range of services.

The President's recommendation to level fund Rehabilitation Training would not allow the Program to begin to address areas of critical training needs and personnel shortages. Ultimately, the overall effectiveness and success of the nation's rehabilitation programs will suffer.

The NRA recommends the full authorization level for Rehabilitation Training to help end rehabilitation personnel shortages and to meet the added demand for trained personnel to work with the severely disabled and professionals in supported employment as called for by Congress.

There also exists significant unmet training needs in rehabilitation facilities. Those needs arise from the current demands placed on community providers in the areas of new technology, emerging populations, and an increasing number of individuals with severe disabilities who have previously been unemployed or underemployed.

To meet this need, the NRA supports the development of a regional system of training resources whereby training would be available to all levels of facility personnel in all areas of the United States.

SUPPORTED EMPLOYMENT SERVICES

The NRA recommends an investment of **$28.06 million** for Supported Employment Services for persons with severe disabilities.

The NRA recommends that Supported Employment be funded at the full amount authorized under Public Law 99-506, the Rehabilitation Act Amendments of 1986. This one-year old program holds great promise for securing employment for individuals who have not traditionally been eligible for rehabilitation services. Several thousand additional persons with severe disabilities could be served in FY 1989 if the program is fully funded.

PROJECTS WITH INDUSTRY

We recommend an investment of **$18.03 million** for the Projects With Industry (PWI) Program.

The PWI Program promotes opportunities for employmwent of Americans with disabilities through grants to State Rehabilitation Agencies, nonprofit rehabilitation facilities, nonprofit community organizations, businesses, labor unions, and trade associations to provide job training, placement assistance, pre-employment and post-employment supportive services for persons with disabilities.

The NRA recommends that Projects With Industry be funded at its full authorization level. The new dollars provided by the increase should be specifically targeted to new and existing projects, thereby allowing the most successful projects to expand their business and industry base to facilitate greater private sector involvement, as well as allowing new and innovative projects the opportunity to replicate the proven success of PWI.

CONCLUSION

Mr. Chairman, as we have previously stated, the Rehabilitation Act of 1973, as amended, is one of the most complete, well-written, and well-balanced pieces of legislation in the field of human services. In one Act, provisions are included for a comprehensive and individually-tailored program of rehabilitation services to eligible physically and mentally disabled persons; a training program to fully prepare rehabilitation personnel; a research program to develop new techniques in providing services; a special projects program to target services to specific populations; a comprehensive services program for independent living for persons too severely disabled to benefit from traditional vocational rehabilitation services: and other specially designed programs.

The Rehabilitation Act and the programs it authorizes signifies our society's recognition of its responsibility to provide citizens with disabilities the opportunity to be full participants in the mainstream of life.

We thank you Mr. Chairman and Members of the Subcommittee in advance for appropriating funds for the Rehabilitation Program at the levels we have recommended in this testimony.

Thank you.

STATEMENT OF PAMELA J. LeCONTE, PROJECT DIRECTOR, COLLABORATIVE VOCATIONAL EVALUATION TRAINING PROGRAM, GEORGE WASHINGTON UNIVERSITY, ON BEHALF OF THE ASSOCIATION FOR EDUCATION OF REHABILITATION FACILITY PERSONNEL

Senator **WEICKER**. Our next witness is Pamela LeConte of the Association for the Education of Rehabilitation Facility Personnel.

Ms. **LECONTE**. Thank you for the opportunity to speak to this group.

My name is Pam LeConte, and I am representing the Association for Education of Rehabilitation Facility Personnel.

Our national association represents educators and trainers from across the country, and we serve all levels of personnel in rehabilitation facilities, community-based organizations and rehab agencies, voc rehab agencies.

Currently I am a project director on an RSA funded grant for training vocational evaluators and assessment personnel at the George Washington University. There is a critical shortage of both preservice preparation and staff development for vocational rehabilitation personnel in this country.

It is not a new problem. Unfortunately, we have had problems providing qualified services for quality services for individuals with disabilities since I entered the rehab field in 1968. Recent national personnel shortage and training needs surveys which you are well aware of conducted in 1987, 1984, and 1983 all conclude the same results. There is a continuous significant manpower shortage of rehab personnel. These shortages are exasperated by low salaries, poor educational and other fringe benefits, and the personnel who do exist and serve in rehab do not receive adequate, often none at all, training to perform employment related preparation for persons with disabilities.

The 36 million persons with disabilities in the United States deserve services and the number of options that able-bodied individuals have regarding employment. They deserve services provided by competent, effective and qualified personnel. Unfortunately, services suffer because we do not have positions that provide even minimal training, certainly not the best money can buy.

These individuals cannot afford the time away from their programs for training because, first of all, there is a manpower shortage. They have to serve their clients. Second, they cannot access training because there is a shortage of training dollars.

And third, in many cases, training is not available due to geographic constraints.

For example, there are 14 vocational evaluation training programs in the country, ours is but 1 of those. We have an average of 10 to 20 requests for positions of trained personnel to our one graduate, per one graduate. This is probably a conservative estimate.

It should be no surprise that over two-thirds of America's persons with disabilities are unemployed, and of the one-third who are employed, they are severely underemployed or working only part time.

The reason this should be no surprise is because there is a direct relationship between the lack of training money and training funds and the low rate of unemployment among the people we are trying to serve.

The number of individuals with disabilities is increasing at a faster rate than the rest of the population, yet our ability to help these people is decreasing. Over 1 million persons with severe disabilities are served by 65,000 staff and over 4,000 rehab facilities. Our staff training needs are reflective of the advancing technology, the increase in disabilities that we have not been asked to serve in the past, and general increases in the disabled population.

PREPARED STATEMENT

We are recommending that the $30 million used by RSA for training is inadequate and that it be increased to a conservative $35 million consistent with the recommendations of the National Rehab Coalition.

Thank you.

Senator WEICKER. Pam, thank you very much. We appreciate your testimony.

[The statement follows:]

STATEMENT OF PAMELA J. LeCONTE

The Association for Education of Rehabilitation Facility Personnel represents educational and training programs whose mission is to upgrade the competencies of personnel employed by rehabilitation facilities to better serve the employment and independent living needs of persons with disabilities. The thirty-six million persons with disabilities in America have the right to be provided rehabilitation services by individuals who are competent personnel. Rehabilitation facilities are relied upon by the state/federal vocational rehabilitation system to provide critical employment-related services. The effectiveness of these services is dependent upon the high quality of facility staff.

The National Assessment of Personnel Shortages and Training Needs in Vocational Rehabilitation (Pelavin, 1987), National Rehabilitation Manpower Needs Assessment (Roberts, 1984), and the Manpower Needs in Rehabilitation Facilities 1980-1990 (Menz, 1983), indicate a significant continuing manpower shortage. These shortages are exacerbated by low salary levels and difficult working conditions causing an unacceptably high staff turnover rate.

The number of individuals with disabilities is growing faster than the population in general. Two-thirds of persons with disabilities in the age group 16-60 are unemployed. Many of the one-third employed are seriously underemployed or employed in part-time jobs without benefits. Qualified rehabilitation facility staff in vocational placement, evaluation, work adjustment, and administration are critical to the provision of services culminating in employment and independent living. Without adequate educational preparation and continuing training to upgrade knowledge and skills, the oportunities available to persons with disabilities is severely compromised.

In rehabilitation organizations, individuals who are hired to administer the facilities generally have backgrounds in human services with little or no experience in management and business practices. In addition, individuals who are hired in entry level direct client service delivery positions are well intentioned, but are not usually prepared educationally to deliver the highest level of professional services expected and desired by persons with disabilities.

Rehabilitation facilities and state vocational rehabilitation agencies, as well as consumers and advocates of rehabilitation services, clearly recognize that programs meeting employment and independent living needs must be intensive, timely, accessible, and of the highest quality. Rehabilitation programs require staff who are well prepared, skilled, and sensitive to the diverse challenging needs of persons with disabilities. Rehabilitation facilities serve the most severely disabled clientele of the state/federal vocational rehabilitation system. Over one million persons with severe disabilities each year are served by 65,000 staff in more than 4,000 rehabilitation facilities.

In addition to manpower shortages, there are also staff training needs which can be categorized in three major areas: 1) technological and program advances, 2) consumer expectations, and 3) improved business practices. Technological advances include the application of rehabilitation engineering to accommodate and adapt work sites to allow severely impaired individuals to achieve in the work place, behavioral techniques to allow individuals who are severely mentally retarded to compete in the private sector, and computer related applications to allow individuals increased access to information. These technological advances have substantially increased the employment options available to persons with disabilities. Consumer expectations have revolutionalized the state/federal vocational rehabilitation system. Persons with disabilities now demand integrated employment opportunities, career advancement, and the right to maintain their productive place in our society. Consumer and advocate involvement have accepted the adoption of new programs, and provide a wholistic treatment approach in service delivery. Rehabilitation facilities must maintain the highest levels of business practices within their organization to assure the availability of resources in order to meet the emerging and complex needs of persons with disabilities.

In summary, facility manpower shortages and training needs necessitate allocating funds to train rehabilitation personnel in facilities to best serve persons with disabilities. Without upgrading the skills and knowledge of current and future staff, the options afforded to persons with severe disabilities will be restricted. There is currently only thirty million dollars to be used by Rehabilitation Services Administration in training which is inadequate to fund this important need. We advocate a planned program to meet these facility training needs through the training program within the Rehabilitation Services Administration. We urge the training level be increased to thirty-five million dollars, consistent with the recommendations of the National Rehabilitation Coalition. There needs to be national coverage on a regional basis in the areas of rehabilitation facility administration, supported employment, rehabilitation workshop and facility personnel, and vocational evaluation and work adjustment. These training categories are critical to the improved delivery of rehabilitation facility services throughout the United States and to the quality of life and choices afforded to persons with severe disabilities.

STATEMENT OF DONALD LINKOWSKI, PH.D., C.R.C., ON BEHALF OF THE NATIONAL COUNCIL ON REHABILITATION EDUCATION

Senator WEICKER. Our next witness is Donald Linkowski of the National Council on Rehabilitation Education.

Mr. Linkowski, nice to have you with us.

Dr. LINKOWSKI. Thank you.

Senator WEICKER. Is that your son that you brought with you?

Dr. LINKOWSKI. Yes.

Senator WEICKER. Why do you not bring him up and let him sit with you?

Dr. LINKOWSKI. Terrific. His name is Adam.

Senator WEICKER. He can tell all of his classmates he has appeared before a congressional committee.

Dr. LINKOWSKI. I have a daughter at home who made me promise to bring back an autograph. [Laughter.]

So if that is possible, I would appreciate that very much.

Senator WEICKER. We will be glad to take care of that. Senator Domenici and I will make sure we send you up one.

What is your daughter's name?

Dr. LINKOWSKI. Her name is Tamara.

Senator WEICKER. Tamara, T-a-m-a-r-a?

She is now on the record also.

What is your son's name?

Dr. LINKOWSKI. His name is Adam.

Senator WEICKER. Adam, nice to have you here.

Please, proceed with your testimony.

Dr. LINKOWSKI. Thank you very much.

Mr. Chairman, members of the subcommittee, my name is Donald Linkowski. I am director of the Rehabilitation Counseling Education Program at George Washington University, representing the National Council on Rehabilitation Education, an organization composed of educators, researchers, training specialists, and students.

NCRE members represent competencies of a variety of rehabilitation personnel who assist a portion of the more than 36 million disabled Americans needing rehabilitation services to find employment and to live as independently as possible.

NCRE works in accord with the Council of State Administrators of Vocational Rehabilitation, the American Rehabilitation Counseling Association, the Association of Educators of Rehabilitation Facility Personnel, the President's Committee on Employment of the Handicapped and other members of the rehabilitation coalition.

Since many of the themes of my testimony have been repeated a number of times this morning, I am going to move in the interests of time to our recommendation, and that is that there be an appropriation, a full appropriation of $35 million for the Rehabilitation Training Program for fiscal year 1989. I think the case for the shortage of rehabilitation personnel has been already made. You will read in our testimony that we have some additional data and information that pertains to the shortage issue.

I would like to also point out that a recent study focused in a major eastern State documented that counselors with a master's degree in rehabilitation counseling have a significantly higher rate of competitive employment closures of clients with severe disabilities than their coworkers who lack such educational preparation.

PREPARED STATEMENT

Personnel of all kinds, however, are needed to serve the rehabilitation program, work adjustment counselors, work evaluators, supervisory personnel and people concerned with the new technologies.

We urge you therefore to please give full consideration to this recommendation.

[The statement follows:]

STATEMENT OF DONALD LINKOWSKI

Mr. Chairman, Members of the Subcommittee, my name is Donald C. Linkowski, Director of the Rehabilitation Counseling Education Program at George Washington University, representing the National Council on Rehabilitation Education (NCRE); an organization composed of educators, researchers, training specialists, and students.

NCRE members represent competencies of a variety of rehabilitation personnel who assist a portion of the more than 36 million disabled Americans needing rehabilitation services to find employment and to live as independently as possible (based on abilities rather than disabilities).

NCRE works in accord with the Council of State Administrators of Vocational Rehabilitation (CSAVR), the American Rehabilitation Counseling Association (ARCA), the Association of Educators of Rehabilitation Facility Personnel (AERFP), the President's Committee on Employment of the Handicapped (PCEH), and other members of the Rehabilitation Coalition.

Background and Overview of Need for and Importance of Full Funding

The history of vocational and independent living rehabilitation services in America is well known. Since rehabilitation's beginning in 1920, it has emerged as an exemplary program for persons with disabilities. It is a model of a State/Federal partnership, is economically sound, and at the same time, humanitarian. Thirty-four years ago, Congress recognized the importance of education/training for those professionals who provided rehabilitation services, on an individual basis, to citizens with disabilities.

As a nation, we have committed ourselves to assisting persons with disabilities by attempting to equalize wherever possible, the disabled person's opportunity to seek and aquire employment and independent living. Reflecting back, we realize how wise an investment the legislation of 1954, which provided Federal support for the systematic preparation of rehabilitation personnel. This resolve was strengthened recently by mandating that rehabilitation personnel responsible for implementing the Rehabilitation Act be "qualified."

The public rehabilitation program continues to be both cost effective and successful in emphasizing services rather than support, rehabilitation rather than relief, and training for meaningful work instead of prolonged dependency. Congress has realized the necessity for having an empirically based system of rehabilitation services. In few programs has the complementary relationship [illegible] education, training, research, and service been so successfully implemented. Both pioneers and contemporaries note the importance of providing quality rehabilitation services. Quality is directly related to the qualifications of providers. Qualified is the key term because it indicates that the practitioner, in performing his or her duties, is ethical, trained, knowledgeable, and skillful.

Currently, a dynamic network of universities offer pre-service and professional education programs. A major result of this networking is a complementary relationship between research, pre-service education and continuing education, and service. The most notable benefit of this type of cooperation is the provision of quality comprehensive services to this nation's citizens who are disabled.

Although our history is replete with successful accomplishments, it should be noted that these advances have been hard fought. Thus, challenges for the current year abound. The need for competent rehabilitation professionals has never been greater; rehabilitation is servicing the most severely disabled, in many cases, persons who would have died if medical techniques and related technology had not significantly improved. In addition, persons with extensive experience and quality educational backgrounds in rehabilitation are entering the age group of citizens who will soon become retirees. This factor alone makes it critical for rehabilitation education to be funded at the highest possible level to include persons in education who are committed to work with persons with disabilities, in this era of students who favor entering highly paid professions in business and industry.

Representing a critical element of service provision to persons with disabilities, are Rehabilitation Training Grants. These grants are made available to institutions of higher education and other public or non private agencies and organizations to help insure that qualified personnel are available to provide services to disabled consumers.

Additionally, in a recent popular survey reported by the President's Committee on Employment of the Handicapped, (representing only one segment of the population with disabilities; persons between the ages of 16 and 64, willing to provide information about their disabilities), a striking 52 percent of persons reporting a disability state that they are prevented by their disability from working. It is unfortunate that these individuals have not had the opportunity to seek professional help from qualified rehabilitation personnel. Based on our experience and research of the past 30 plus years, it is clear that trained contemporary rehabilitation counselors are critical if an effective and efficient delivery system is to be maintained. The success of the rehabilitation program is in large part dependent on the availability and maintenance of competent professionals. A qualified rehabilitation person must possess a multitude of knowledge and skills which are best acquired through specialized pre-service education and post-employment training. The system of rehabilitation in this country has great potential. It is conceptualized and implemented in developmental sequential fashion which has the greatest potential of success. It's demise and/or reduced potential is hastened in large part by inadequate funding.

NCRE FY 1989 Funding Recommendation

The National Council on Rehabilitation Education recommends an appropriation of $35 million for the Rehabilitation Training Program for fiscal year 1989.

Justification and Summary

Evidence abounds to document that there is a shortage of qualified rehabilitation personnel available for working with severely disabled persons. If funding is not provided at the full funding level of $35 million, this will further reduce the severely disabled person's opportunity to be provided services by a qualified individual. But the long term ramifications are even more devastating — specifically, reduced opportunity to enter and succeed in the workforce or to live as independently as assets would allow.

The following are examples of information substantiating the need for full funding and existence of personnel shortages:

1. In a comprehensive research study (1987), from the National Institute on Disability and Rehabilitation Research (NIDRR) to the National Council on Rehabilitation Education, results abound documenting the need for qualified practitioners, the unquestionable value of pre-service (M.S.) education, and the commitment of M.S. persons to the State Vocational Rehabilitation (VR) Agency.
2. Stout Vocational Rehabilitation Institute (1983) further documents the need for capable personnel as reflected in their Person Power Needs Study.
3. The Council of State Administrators of Vocational Rehabilitation provided the results of a major survey of all State Rehabilitation Agencies, blind and general, where Rehabilitation Counseling ranked as number 1 as an area of need and priority for funds to reduce personnel shortages.
4. A research study, focused on a major eastern State, documented that counselors with master's degrees in Rehabilitation Counseling have a significantly higher rate of competitive employment closures of clients with severe disabilities than their co-workers who lack such educational preparation.
5. The Rehabilitation Counselor is the key staff person in public rehabilitation programs and rehabilitation facilities.
6. Work Adjustment Counselors and Work Evaluators are principally employed by rehabilitation facilities to assist persons with disabilities in making the

transition to work. By 1990, there is an estimated increase of 87 percent in the need for such facility personnel.

7. Rehabilitation Supervisory Personnel are needed to manage rehabilitation facilities across the nation. It is projected that a growth of 69 percent of this type of personnel will be in place by 1990. Placement Specialists who work for both the State VR Agency and facilities are crucial in terms of employer contacts and increased need to deal with severely disabled individuals in finding employment. In the field of rehabilitation, specialists working with individuals who are deaf and/or blind, mentally ill, and traumatically brain injured, are expected to be in short supply when such qualified personnel are needed.
8. New technology, including use of computers to enhance the capabilities of persons with disabilities, new surgical and medical techniques, extraordinary recovery based on contemporary medical intervention and newly discovered rehabilitation principles specific to disabilities types and among rehabilitation providers, translates into more complex skills required of rehabilitation personnel rather than less.
9. In-service and continuing rehabilitation training are integral components of the total rehabilitation education and training endeavor. It is intended to maintain the knowledge and competencies of qualified rehabilitation personnel to meet the needs of persons with disabilities in a dynamic contemporary society. The benefit of continued and enhanced Federal support for continuing education and in-service training is warranted. For example, rehabilitation personnel want and need continuing education; rehabilitation educators and professional trainers are also in need of continued education based on the dynamic nature of rehabilitation. New client populations, legislation and societal demands result in continuing need for skills upgrading.

A subcommittee of NCRE (Graves, Coffey, Habeck and Stude, 1987), eloquently state the commitment of NCRE:

> The National Council on Rehabilitation Education (NCRE) was organized by faculty members from universities having pre-service curriculums, continuing education programs, and research and training programs for the education and training of rehabilitation professionals. The purpose of NCRE is to assist Congress, Federal agencies, State Rehabilitation and other agencies, consumers, and other groups to improve quality of life for people with disabilities through the educational, research, and informational services of its membership.

Mr. Chairman, the National Council on Rehabilitation Education is prepared to assist you and this Subcommittee in any way possible to achieve our mutual goals of insuring quality rehabilitation services to consumers with disabilities and through the preparation and maintenance of qualified rehabilitation professionals. The inclusion of persons with disabilities (including minorities) can only occur if Federal funds are targeted for rehabilitation education, training, and research.

Thank you for this opportunity to convey the urgency of needs of persons with disabilities and for full funding for Rehabilitation Training for fiscal year 1989.

Senator WEICKER. Mr. Linkowski, thank you very much for your testimony. It is greatly appreciated, and the staff is going to go ahead and make sure that Adam and Tamara get their autographs.

I am not so sure that is a good thing, Adam. You know, that and a nickle will get you a cup of cocoa.

Dr. LINKOWSKI. This will excuse his absence from school.

Senator WEICKER. Nice to have you both here.

Senator DOMENICI. Could I just ask him one question, Mr. Chairman?

Senator WEICKER. Of course. I beg your pardon.

Senator Domenici.

Senator DOMENICI. What are your general thoughts as to how we are going to get more people interested in this field?

Normally in the United States if you look back at the college educational system versus American needs, obviously they go through ups and downs in terms of demand. When there is a demand for engineers and everybody knows they can get a good job, your colleges are filled with people who want to be engineers. I still have a lingering notion that in the field we are talking about, because of low pay, the difficulty of the job, that we may have just an indigenous, inherent shortage that we have to address in some other way.

Do you have any thoughts about that?

Dr. LINKOWSKI. You are absolutely correct, that it is very hard to recruit people, much harder these days than in the past. I have been in the field of education for over 25 years now, and it is getting a little better. I think we have bottomed out in terms of the lack of interest in some of the human service fields. I think people again are starting to move toward these professions.

I think the need points to two things. One, the job situation needs to be improved. The salaries have not kept up with the economy at all. So I think we need to attack the job conditions.

Also the stresses you mentioned. The work is very, very difficult, the load is very, very high, and we need to provide some kind of assistance to people who are employed in this field to cope effectively with the work situation.

However, it is very clear to me that if we can provide incentives through traineeships for students to come into this field, people will come into this field. I think people want to come into this field, but they need some leverage to move into it. And so I think it is absolutely essential that there be full funding for training programs.

Senator DOMENICI. Thank you.

Thank you, Mr. Chairman.

Senator WEICKER. Thank you, Senator Domenici. Thank you both.

Dr. LINKOWSKI. Thank you.

STATEMENT OF ROBERT R. DAVILA, PH.D., PRESIDENT, CONFERENCE OF EDUCATIONAL ADMINISTRATORS SERVING THE DEAF; AND VICE PRESIDENT, PRECOLLEGE PROGRAMS, GALLAUDET UNIVERSITY

Senator WEICKER. Dr. Robert Davila, president of the Conference of Educational Administrators Serving the Deaf.

Dr. DAVILA. Mr. Chairman, thank you for the opportunity to be here today. I am president of the Conference of Educational Administrators Serving the Deaf. I am also the vice president, Gallaudet University. The organization that I represent is an organization of schools and programs serving the hearing impaired in this country. Our membership includes nearly all State operated general schools for the deaf. We also have among our membership many public school programs in the main stream.

My purpose in coming here today is to support continued funding for services provided under Public Law 89-313, chapter 1 of the ACIA.

Schools for the deaf receiving support under Public Law 89-313 serve profoundly, prelingually deaf students whose educational, communication, and social/emotional needs are significant. Schools with programs for the deaf in 45 States are currently receiving support through this chapter.

Schools for the deaf use Public Law 89-313 funds to support a variety of creative and innovative programs for the hearing impaired, including computer applications, parent education, special programs for minority deaf children, and services for the multihandicapped among other things.

My testimony has focused on the benefit that deaf students in special residential schools receive through this support. A good example of how deaf and hard of hearing students in any type of educational setting benefit from this program is found in the State of Florida.

Now, Florida's School for the Deaf and Blind uses chapter 1 funds not only to serve children on its campus in St. Augustine, but also to serve hearing impaired children throughout the State in public schools.

A portion of the schools' chapter 1 appropriation is paired with State funds to support television encaptioning production. It is made available to deaf children in all programs across the State.

At the Florida School for the Deaf and Blind also, as well as at other similar schools in other States, chapter 1 funds are important to the establishment and maintenance of partnerships that lead to new and innovative ways of educating the deaf, partnerships with State funding and with every conceivable type of educational program serving hearing impaired children.

Congress passed Public Law 89-313 to foster creative and innovative programs. It serves this purpose well. I am confident that when the Government Accounting Office study of this program is completed, it will strongly document its effectiveness.

I urge the subcommittee's support of an appropriation of $167 million for the important services provided through this program. This figure would allow for a modest increase, to allow for inflationary increases over the last 7 years.

PREPARED STATEMENT

Thank you very much, Mr. Chairman, for the opportunity to come here and present this information to you.

[The statement follows:]

STATEMENT OF ROBERT R. DAVILA

The Conference of Educational Administrators Serving the Deaf (CEASD) was founded in 1869, and is an organization of schools and programs, whether private or public, providing educational services to deaf persons. Nearly all state-operated and state-supported schools for the deaf are members of CEASD. Our membership also includes a significant representation of local program models of various types serving disabled persons as well as state education department personnel. We are pleased to have the opportunity to address this subcommittee regarding our concerns for quality educational programming for the deaf as they relate to FY 1989 appropriations for programs serving persons with disabilities.

The state-operated and supported schools among our membership are representative of the programs most likely to be recipients of funds under Chapter I of the Educational Consolidation and Improvement Act of 1981, also known as P.L. 89-313. Because of our membership's knowledge of the significant impact these funds have had on educational opportunities for deaf children, our main testimony is in support of the reauthorization of P.L. 89-313 and its continued funding. We are interested, of course, in all aspects of all programs for the education of the deaf.

It is the position of CEASD that the provisions of Public Law 89-313 should remain intact and that its funding level for FY 1989 should be 167 million dollars.

The importance of P.L. 89-313 funds to the education of the deaf children is clear. In addition to state and local funding, handicapped children receive funding from two essential federal sources: P.L. 94-142 and P.L. 89-313. The majority of CEASD member schools, which are state-operated or state-supported, receive little or no funding from P.L. 94-142, due to state and federal guidelines, except the unusual case where funds come from the discretionary portion of a state's allotment. As a result, P.L. 89-313 funds form a strong foundation for services to handicapped children in state-operated and state-supported programs.

Schools for the deaf receiving Chapter I funds generally serve profoundly, prelingually deaf students whose educational, communication, and social/emotional needs are significant. It is these schools that provide an appropriate education in the "least restrictive environment" for students 0-21 years of age. Should federal support be reduced or withdrawn, state and local school programs would be unable to make up for diminished and/or lost services, resulting in many deaf students being denied the full range of services they need to grow and develop as full citizens.

Any efforts to revamp Chapter I, i.e. reducing support for disabled children, would likely have a disastrous effect on the education of deaf children. The fact is that deaf students in state operated and supported schools have been the beneficiaries of past federal support with significant results. For example, Gregory Hlibok, the student leader at Gallaudet University who has served as a national leader and spokesman during the recent activity on our campus, has acknowledged publicly that his leadership skills were developed at his high school, the Lexington School for the Deaf. The leadership training program for deaf adolescents at Lexington was and continues to be a part of a P.L. 89-313 project.

Public Law 89-313 was established by Congress to foster creative and innovative programs. It has enabled state operated and supported schools and programs to move beyond traditional methodologies and strategies leading to programs and activities that have resulted in significant advances. Some of the activities for deaf students supported by these funds include computer laboratories; parent education to help families accept their infant's deafness; special programs for minority deaf children whose multicultural backgrounds represent impediments to educational development; the creation of effective therapeutic mental health services, where none have existed for deaf persons, focusing on prevention and treatment of mental illness; and programs for severely multihandicapped deaf children who otherwise would have been hospitalized.

These funds are used to serve students virtually nation-wide. Forty-five states currently report projects funded through Chapter 1 specifically for deaf children and youth or their families.

As a result of the Gramm-Rudman-Hollings sequestration order and the 4.26 percent across-the-board cut resulting from the budget summit agreement, P.L. 89-313 has been cut significantly over the past two years.

Mr. Chairman, CEASD urges your support of an appropriation consistent with the Consortium for Citizens With Developmental Disabilities' recommendation of $167 million for the important services provided through P.L. 89-313. This figure would allow for a modest, but badly needed increase to account for the effects of inflation in program costs and the increased number of participating children over the past seven years.

We urge your continued support for programs providing educational and related services to deaf children. Thank you.

Senator WEICKER. Thank you very much, Dr. Davila.

As I understand it—that is why I was talking to counsel—these are the chapter 1 funds that go to the States for State use.

Am I correct on that, on behalf of the disabled?

Dr. DAVILA. That is correct. The funds are appropriated to center schools, State operated schools, and they are used for the purpose of developing creative programs to support the education of the children in those schools.

Senator WEICKER. These funds, counsel tells me, are frozen as between 1988 and 1989.

Is that correct?

Dr. DAVILA. Yes.

Senator WEICKER. Would that mean that there would be less served?

Dr. DAVILA. That is correct. We see an increase in the number of children being served, but obviously there is a need for an increase in funds.

Senator WEICKER. Senator Domenici?

Senator DOMENICI. No questions.

Senator WEICKER. Dr. Davila, thank you very much.

Dr. DAVILA. Thank you, sir.

Senator WEICKER. Thank you.

Our next witness is Mr. William Roberts, president of the National Association of Rehabilitation Professionals in the Private Sector.

STATEMENT OF ALTAMONT DICKERSON, JR., PH.D., COMMISSIONER, VIRGINIA DEPARTMENT OF REHABILITATIVE SERVICES, ON BEHALF OF THE COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

If Mr. Roberts is not here, we will hear from Altamont Dickerson, Jr., Council of State Administrators of Vocational Rehabilitation.

Dr. DICKERSON. Thank you, Mr. Chairman.

The Council of State Administrators of Vocational Rehabilitation [CSAVR] is comprised of the chief administrators of public rehabilitation agencies providing services to eligible persons with disabilities in the 50 States, the District of Columbia, and our Nation's territories.

These agencies are the State partners in the State-Federal Program of Rehabilitation Services for persons with mental and/or physical disabilities, as authorized by the Rehabilitation Act of 1973, Public Law 93-112 as amended.

The provision of the comprehensive services under Public Law 93-112 results in a direct savings to government, as competitive work generates increased tax revenue, and as decreased dependence saves public assistance and other expenditures.

In the Rehabilitation Act, provisions are included for, one, a comprehensive and individually tailored program of rehabilitation services to eligible physically and/or mentally handicapped individuals; two, an innovation and expansion program; three, a training program; four, a research program; five, a special projects program; six, a rehabilitation facilities program; seven, a comprehensive services program for independent living; and eight, a supported employment program.

Basic State service grants are the lifeblood of the Vocational Rehabilitation Program, financing the provision of vocational rehabilitation services to eligible individuals with mental and physical disabilities.

These Federal dollars, matched with State moneys, enable State rehabilitation agencies to provide or contract with private organizations and agencies to provide individualized, comprehensive services to people with mental and/or physical disabilities for the purpose of rendering these individuals employed and independent.

However, there are still not sufficient funds to serve all those eligible, disabled people who have the potential and desire to work and who need rehabilitation services to obtain employment and self-sufficiency. Alarmingly enough, our best estimates are that State rehabilitation agencies are able to serve only 1 out of every 20 people who are eligible.

PREPARED STATEMENT

The council strongly urges that the Congress provide Federal appropriations for basic State vocational rehabilitation services in the amount of $1,550,000,000 for fiscal year 1989. A recent CSAVR study found that should Congress appropriate $1.550 million for fiscal year 1989, an additional 71,000 people with disabilities will receive these vital rehabilitation services.

Thank you, Mr. Chairman.

Senator WEICKER. Thank you, Dr. Dickerson.

[The statement follows:]

STATEMENT OF ALTAMONT DICKERSON, JR.

COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

The Council of State Administrators of Vocational Rehabilitation is comprised of the chief administrators of the public rehabilitation agencies providing services to eligible persons with disabilities in the fifty states, the District of Columbia, and our Nation's territories.

These agencies are the state partners in the State-Federal Program of Rehabilitation Services for persons with mental and/or physical disabilities, as authorized by the Rehabilitation Act of 1973, P.L. 93-112, as amended.

The Rehabilitation Act is recognized as the most complete and well-balanced legislation in the human services field.

Its purpose is the provision of comprehensive services to persons with mental and/or physical disabilities, enabling them to re-enter the workforce or obtain employment for the first time, and to become independent of public assistance, publicly-funded health care, or family support.

The provision of these services results in a direct savings to government, as competitive work generates increased tax revenue, and as decreased dependence saves public assistance and other expenditures.

In the Rehabilitation Act, provisions are included for (1) a comprehensive and individually-tailored program of rehabilitation services to eligible physically and/or mentally handicapped individuals; (2) an innovation and expansion program; (3) a training program; (4) a research program; (5) a special projects program; (6) a rehabilitation facilities program; (7) a comprehensive services program for independent living; and (8) a supported employment program.

VOCATIONAL REHABILITATION SERVICES: BASIC STATE GRANTS

Section 110

FY 1989 CSAVR RECOMMENDATION........$1,550,000,000
FY 1989 AUTHORIZATION...............$1,550,000,000

Basic State Service Grants are the lifeblood of the Vocational Rehabilitation Program, financing the provision of vocational rehabilitation services to eligible individuals with mental and physical disabilities.

These Federal dollars, matched with state monies, enable State Rehabilitation Agencies to provide, or contract with private organizations and agencies to provide, individualized, comprehensive services to people with mental and/or physical disabilities, for the purpose of rendering these individuals employed and independent.

Such services may include evaluation; comprehensive diagnostic services; counseling; physical restoration; rehabilitation engineering; prosthetic devices; the provision of various kinds of training and training supplies, tools and equipment; placement; transportation; post-employment services; and any other service needed to rehabilitate an individual into employment.

For Fiscal Year 1987, the last year for which there are complete records, the $1,281,000,000 appropriated for Basic State Vocational Rehabilitation served 917,482 disabled individuals, of whom 219,626 were rehabilitated into employment.

Despite this expenditure, there still are not sufficient funds to serve all those eligible, disabled people who have the potential and desire to work and who need rehabilitation services to obtain employment and self-sufficiency.

Alarmingly enough, our best estimates are that State Rehabilitation Agencies are able to serve only one out of every twenty people who are eligible, due to scarce resources.

State Rehabilitation Agencies, in carrying out the mandate of the Act to give priority of service to the rehabilitation of individuals who are severely disabled, are finding that the costs, in time, effort, and money of serving this group are great -- much greater than the cost of rehabilitating less severely disabled people. (Over 50 percent more costly than those to persons who are not severely disabled).

In spite of this, it is alarming to note that **the purchasing power of the Federal Rehabilitation Appropriation increased by only 1.8 percent from 1980 to 1988.** This worrisome statistic was provided to the Congress by the Congressional Research Service.

This means that the Program is serving fewer people, while expending more money for adequate services, adequately-trained staff, adequate equipment, and adequate facilities.

63.8 percent of all individuals served by State Rehabilitation Agencies in FY 1987 were classified as "severely disabled" -- by the Federal Rehabilitation Services Administration. This is the highest percentage of persons with severe disabilities served in the history of the Program.

With these statistics in mind, and ever cognizant of the vast need for services, **the Council strongly urges that the Congress provide Federal appropriations for Basic State Vocational Rehabilitation Services in the amount of $1,550,000,000 for Fiscal Year 1989.**

A recent CSAVR Survey of all State Rehabilitation Agencies found that **SHOULD the Congress appropriate $1,550 million for FY 1989, an additional 71,000 people with disabilities will receive these vital rehabilitation services.**

The justification for higher funding levels stems from the purpose for which the money is spent--the prevention of an incalculable waste of human potential--a purpose on which no price tag can be placed.

Appropriating additional monies for Vocational Rehabilitation Services reduces the Federal Deficit.

Over the decades, Vocational Rehabilitation has more than paid for itself by helping persons with disabilities increase their earning capacity; by freeing family members to work; and/or by decreasing the amount of welfare payments, health services, and social services they might need; as well as by assisting them to become taxpayers.

There is a return to Federal and state treasuries of over ten dollars for every dollar spent for Rehabilitation Services, according to the Federal Rehabilitation Services Administration.

Funds appropriated for Vocational Rehabilitation are a sound investment of the Public's money.

OTHER PROGRAMS AUTHORIZED BY REHABILITATION ACT

While the CSAVR's Statement focuses on the major service delivery component of the Rehabilitation Act -- Basic State Rehabilitation Services -- the CSAVR supports adequate funding for all Sections of the Act, and wholeheartedly joins with the recommendations and rationale provided this Panel by other Organizations and Advocates.

These call for FY 1989 funding at the full authorization level for Rehabilitation Training and Research; Comprehensive State Independent Living Services; Independent Living Centers; Independent Living for Older Blind Individuals; Supported Employment State Grants; and for the other Service Programs and Demonstration Projects authorized by the Rehabilitation Act.

STATEMENT OF BETSEY BREWSTER CASE, ESQ., CHAIRMAN OF THE BOARD, ARTHRITIS FOUNDATION

Senator WEICKER. Next we call Ms. Betsey Brewster Case, chairman of the board of the Arthritis Foundation.

Ms. Case, we are pleased to have you with us.

Ms. CASE. Mr. Chairman and members of the committee, my name is Betsey Brewster Case. I am chairman of the board of the Arthritis Foundation and a partner in the Columbus, OH, office of Thompson, Hine & Flory. May I also say that I am pleased and honored to appear before Congress in which my grandfather, Owen Brewster, served as a U.S. Senator from my native State of Maine, which I still claim as home and where my father, Charles Foss Brewster, resides.

I am appearing today on behalf of the Arthritis Foundation, which is a national voluntary health organization based in Atlanta, GA, with 71 chapters throughout the United States.

The interest of the Arthritis Foundation is appropriations for the National Institute of Arthritis and Musculoskeletal and Skin Diseases. This derives from our commitment to the more than 38 million Americans who have arthritis. Research and training supported through the newest NIH Institute have direct and profound effects on people with arthritis.

As this committee knows, NIAMS was established by legislation passed in 1985. This success required 4 years of intensive advocacy work on the part of Arthritis Foundation volunteers and staff, concerned legislators, and other disease groups. As a result, NIAMS is able to give greater focus to Federal arthritis research activities than has previously been possible.

Since then, NIAMS has embarked on an implementation plan to establish itself as an independent entity. The Coalition of Organizations Concerned with the Programs of NIAMS, a group of 30 organizations that includes the Arthritis Foundation, has monitored the progress of the NIAMS implementation plan.

NIAMS presently supports 23 multipurpose arthritis centers which account for 23 percent of the entire Institute's budget. These centers are designated to support basic and clinical research programs which are vital in discovering new scientific information essential for the control of the over 100 forms of this disease; provide a mechanism for the rapid and effective application of research findings into clinical practice; and provide educational programs for health care professionals regarding arthritis-related disorders.

In the 1988 appropriation and the 1989 President's budget request, funding for the centers, which will total 26 this fiscal year, has remained unchanged at $22 million. The result of this level of funding has meant a 15-percent reduction in 1988 and 16.3-percent reduction in 1989. To fully fund the centers, a total level of $26.2 million is necessary.

The Arthritis Foundation is advocating that the Congress fully fund the existing centers as well as seven additional centers, which wouid allow NIAMS to restore the full capabilities of existing centers as well as establish the new centers.

The Arthritis Foundation is also deeply concerned about the erosion of support for research training. Training of experts cannot be done overnight. On average, it requires approximately 8- to 10-years postbaccalaureate education to train a scientist.

We also feel that more attention needs to be given to the NIH infrastructure and resources that underlie NIH funded research.

The Arthritis Foundation, along with the NIAMS Coalition, asks that you support funding of about $224 million for fiscal year for NIAMS. This appropriation reflects funding for research programs which the Institute believes should be funded based upon scientific judgment. We need this level of funding to produce an adequate supply of scientists as well as to support scientists in the field of arthritis and to fully continue the efforts of arthritis research.

PREPARED STATEMENT

Thank you, Mr. Chairman. I will be pleased to respond to any questions.

Senator WEICKER. I thank you very much.

Ms. CASE. Thank you.

[The statement follows:]

STATEMENT OF BETSEY BREWSTER CASE

Mr. Chairman, and members of the Committee, my name is Betsey Brewster Case. I am Chairman of the Board of the Arthritis Foundation and a partner in the Columbus, Ohio office of Thompson, Hine and Flory. May I also say that I am pleased and honored to appear before Congress, in which my grandfather, Owen Brewster, served as a United States Senator from my native state of Maine, which I still claim as home and where my father, Charles Foss Brewster, resides. I appear today on behalf of the Arthritis Foundation. The Arthritis Foundation is a national voluntary health organization based in Atlanta, Georgia with 71 chapters throughout the United States. The interest of the Arthritis Foundation is appropriations for the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS). This derives from our commitment to the more than 38 million Americans who have arthritis. Research and training supported through this newest NIH Institute have direct and profound effects on people with arthritis.

As this Committee knows, NIAMS was established by legislation passed in 1985. This success required four years of intensive advocacy work on the part of Arthritis Foundation volunteers and staff, concerned legislators, and other disease groups. As a result, NIAMS is able to give greater focus to federal arthritis research activities than has previously been possible.

Since that time, NIAMS has embarked on an implementation plan to establish itself as an independent entity. The Coalition of Organizations Concerned with the Programs of NIAMS, a group of 30 organizations that includes the Arthritis Foundation, has monitored the progress of the NIAMS implementation plan.

NIAMS carries out a number of research efforts through extramural support--grants and contracts--and intramurally in the research laboratories on the NIH Bethesda campus. NIAMS funding is predominantly going for grants and contracts outside of the NIH, accounting for 91 percent of the budget.

Grants, which comprise 67 percent of the Institute's research efforts, are initiated by scientific investigators across the country, each of whom submits an application for funding to the Institute for a clearly defined research project. The application is carefully reviewed by a "peer review" system and given a scientific "score". The lower the score, the better. If the score falls within a predetermined approval range and sufficient funds are available, the grant of money is awarded to the investigator to support his or her research. The payline for NIAMS is 140, the lowest payline of any NIH program. The average payline of the NIH is 160. This means that this Institute is one of the most competitive of all the Institutes and funding the best research of all of NIH.

The 1989 President's Budget Request will support, once again, a payline of only 140. This will permit NIAMS to fund only 22% of the approved grants. Mr. Chairman, we believe that NIAMS should be more in line with the rest of the NIH. In that regard, $13.6 million above the President's Budget Request would be necessary to establish a payline of 150. To meet a payline of 160, the average NIH payline, $20 million above the President's Budget Request is required. A payline of 160 would permit the NIAMS to fund 35% of the approved grants.

NIAMS presently supports 23 Multipurpose Arthritis Centers which account for 23 percent of the entire Institute's budget. These Centers are designed to:

*support basic and clinical research programs which are vital in discovering new scientific information essential for the control of the over 100 forms of this disease;

*provide a mechanism for the rapid and effective application of research findings into clinical practice; and

*provide educational programs for health care professionals regarding arthritis-related disorders.

In the 1988 appropriation and the 1989 President's Budget Request, funding for the Centers, which will total 26 this fiscal year, has remained unchanged at $22 million. The result of this level of funding has meant a 15% reduction in 1988 and a 16.3% reduction in 1989. To fully fund the Centers to carry out their mission, an additional $4.2 million would be necessary in FY 1989, for a total level of $26.2 million.

The Arthritis Foundation is advocating that the Congress fully fund the existing Centers as well as fund 7 additional Centers: 4 SCORE Skin Centers, 2 Multipurpose Arthritis Centers and 1 Specialized Center for research into children with arthritis. This will allow NIAMS to restore the full capabilities to the existing Centers as well as establish new Centers to meet the needs of this growing area of science.

The Arthritis Foundation is also deeply concerned about the erosion of support for research training. Unless funding is increased, no new Clinical Investigator or Physician Scientist Awards would be available. Without training for an adequate number of new and established scientists, we will discover within a few years that the cutting edge of biomedical research will have been lost along with this nation's preeminence in the field.

Training of experts to maintain and enhance our research efforts cannot be done overnight. Training of future clinicians and scientists is a long-term commitment. On the average, it requires approximately 8 to 10 years post-baccalaureate education to train a scientist. We need to closely examine the needs of and provide the necessary support for all levels of scientific training in order to recoup the growing deficit of this nation's valuable resource -- trained scientific experts.

On another note, we feel that the more attention needs to be given to the NIH infrastructure and resources that underlie NIH funded research. These resources include research training and career development, particularly for physician researchers, state of the art equipment, expanded and upgraded research facilities. The absence of a renewed federal investment in the research infrastructure will jeopardize the capability of our nation's research institutions to develop and pursue current and future scientific opportunities.

ARTHRITIS IN CHILDREN

One exciting research area is the recent progress in combatting juvenile arthritis. Arthritis in children affects about 165,000 children in the U.S. Its onset can begin at any age and severe retardation in growth is one of the many problems frequently associated with the many forms of this disease. Recently, researchers have found that juvenile arthritis is associated with several tissue type antigens; potentially linking juvenile arthritis to genetic factors. With this new information, it is now imperative that we begin to explore factors associated with the genetic susceptibility. For the first time, researchers are continuing to explore this field of research of the cause of juvenile arthritis -- these and other advances may finally lead to the development of therapeutic interventions in the management of this disease.

The Arthritis Foundation is supporting increased funding for juvenile arthritis in order that we can respond to this new information in a timely fashion.

FUNDING

For fiscal year 1988, Congress appropriated $147.7 million for NIAMS -- $11 million more than the year before. The FY 1988 appropriation for NIAMS represents less than 3 percent of the total appropriation for NIH, even though arthritis affects more Americans than any other condition except heart disease. Each person who has arthritis loses about $150,000 during his or her lifetime in lost wages and medical care. There are about 7 million people disabled by arthritis and an estimated $1 billion is spent annually on disability aid and insurance.

Foregoing research opportunities now would be a false economy. The Arthritis Foundation is deeply concerned that the momentum generated through federal arthritis research activities will be lost if more funds are not allocated to NIAMS.

In conclusion, the Arthritis Foundation, along with the NIAMS Coalition, asks that you support funding of about $224 million for FY 1989 for NIAMS. This appropriation reflects funding for research programs which the Institute believes should be funded based upon scientific judgment. We need this level of funding to produce an adequate supply of scientists as well as to support scientists in the field of arthritis and to fully continue the efforts of arthritis research.

Mr. Chairman and members of the Committee, thank you for the privilege and opportunity to present testimony on behalf of the Arthritis Foundation. I will be pleased to respond to any questions.

STATEMENT OF ROBERT R. HUMPHREYS, NATIONAL ADMINISTRATOR AND COUNSEL, AFFILIATED LEADERSHIP LEAGUE OF AND FOR THE BLIND OF AMERICA

Senator **WEICKER**. Next we will hear from Robert R. Humphreys, national administrator and counsel, Affiliated Leadership League of and for the blind of America [ALL].

We are pleased to have you, Mr. Humphreys.

Mr. **HUMPHREYS**. Senator, it is nice to see you.

I have a prepared statement to submit, and I will summarize.

Senator **WEICKER**. It will be included in the record in full, as if read.

Mr. **HUMPHREYS**. Thank you.

The Affiliated Leadership League of and for the Blind of America is a coalition organization comprised of national, State, public and private groups whose missions relate to blindness and blind and visually impaired persons. Nearly 70 such organizations are ALL members. My testimony this morning is endorsed by a number of member organizations. The focus of our statement is on funding for the Office of Special Education and Rehabilitative Services and its component agencies.

I would like to call the committee's attention to two major problems which deeply concern us and which deserve immediate attention by the Congress. First, recent history demonstrates a lack of control by the RSA Commissioner, a Presidential appointee confirmed by the Senate, over the agency he is supposed to administer. Second, there is a deep and unlawful attrition of personnel in the RSA Division for the Blind and Visually Impaired. The last RSA Commissioner was forced to resign because he wanted to run his own agency. The Division for the Blind is at a staffing level which precludes any substantial program oversight or direction. Every employee in the Division has been downgraded. The Randolph-Sheppard Act [RSA] for the Blind requires at least 13 full-time equivalent positions be assigned to the program. The number is now 10, including fractions of positions in the regional offices. We are available to discuss the matter in depth at any time with members of this committee or their staffs.

The Affiliated Leadership League is particularly concerned about funding for several programs administered by RSA and urges adequate funding for each of them, including the Randolph-Sheppard Blind Vending Facility Program, title VII, part C program of independent living services for older blind individuals, and the Helen Keller National Center for Deaf Blind Youths and Adults.

The Office of Special Education Programs funds provide partial support for residential schools for the blind, which ALL and its members strongly endorse as a necessary option in the statutorily mandated continuum of services for blind and visually impaired children. State-operated programs are funded under Public Law 89-313. We believe this program should receive an appropriation of $167 million in fiscal year 1989.

PREPARED STATEMENT

The American Printing House for the Blind is an institution of great importance to blind and severely visually impaired personal.

Its appropriation has been essentially level for a number of years. We believe an appropriation of $6 million for fiscal year 1989 would be eminently reasonable.

Thank you, Mr. Chairman.

Senator WEICKER. Thank you, Mr. Humphreys.

[The statement follows:]

STATEMENT OF ROBERT R. HUMPHREYS

Mr. Chairman and Members of the Committee, my name is Robert Humphreys. I am National Administrator and Counsel of the Affiliated Leadership League of and for the Blind of America (ALL), a coalition organization comprised of national, state, public and private groups whose missions relate to blindness and blind and visually impaired persons. Nearly 70 such organizations are ALL members. My testimony this morning is endorsed by a number of member organizations, including the American Council of the Blind, the American Foundation for the Blind, the Association for the Education and Rehabilitation of the Blind and Visually Impaired, and the Blinded Veterans Association. The focus of our statement is on funding for the Office of Special Education and Rehabilitative Services and its component agencies.

Before addressing appropriations issues, however, I want to call the Committee's attention to two major problems which deeply concern us, and which deserve immediate attention by the Congress. Because of the dedication and interest of the newly appointed Acting Commissioner of the Rehabilitation Services Administration we are hopeful that these problems will be resolved. Nonetheless, we would be remiss in not raising them. First, recent history demonstrates a lack of control by the RSA Commissioner, a presidential appointee confirmed by the Senate, over the agency he is supposed to administer; second, there is a deep and unlawful attrition of personnel in the RSA Division for the Blind and Visually Impaired. The last RSA Commissioner, was forced to resign because he wanted to run his own agency. The Division for the Blind is at a staffing level which precludes any substantial program oversight or direction. Every employee in the Division has been downgraded. The Randolph-Sheppard Act for the Blind requires at least 13 full-time equivalent positions be assigned to the program. The number is now 10, including fractions of positions in the regional offices. We are available to discuss the matter in depth at any time with Members of this committee or their staffs.

Rehabilitation Services Administration

The Affiliated Leadership League is particularly concerned about funding for several programs administered by RSA, and urges adequate funding for each of them. The Randolph-Sheppard Blind Vending Facility program has been in existence since 1936. It was overhauled in 1974 after pervasive complaints of inadequate Federal attention and support. For 52 years the program has operated largely through funds generated from sales by the vendors themselves. There has never been a Federal appropriation for the program, although Federal funding is authorized by the Randolph-Sheppard Act. Although the 1974 amendments to the Act anticipated a doubling in the size of the program within five years, the result has been disappointing. There are no greater number of blind vending facilities on Federal property now than there were in 1974. One of the reasons is the antagonism of the Defense Department and certain other agencies toward the program. Another major reason, however, is inadequate resources. Several years ago, this organization, the American Council of the Blind, and others urged Congress to appropriate Federal funds for the creation of new blind vending facilities throughout the country. We believe $100 million can be effectively and efficiently spent in a one-time infusion of funds for this purpose. Budget constraints would not allow this committee to provide anything approaching the amount we believe is needed, but we urge you to make a start by recommending the appropriation of $5 million for Randolph-Sheppard blind vending facilities in FY 1989. The Title VII, Part C program of independent living services for older blind individuals was funded for the first time two years ago through the efforts of the Chairman of this Subcommittee and others. The services provided under this program have filled a major gap in the needs of many blind persons, and we urge that funding be expanded slightly. The appropriation for FY 1988 was $5.6 million, and the President has requested the same amount for FY 1989. We believe Congress should fund this program at the full authorized amount, $5.93 million. The Helen Keller National Center for Deaf Blind Youths and Adults, the only such center in the world, has been in operation as a federally sponsored, statutorily mandated institution since 1969. It not only provides residential services to about 80 multiply and severely disabled young people each year, it also serves as a training center for teachers and other workers with the deaf-blind, as a national resource center, as the core of a national service network, and as a research facility. In order to provide services to young people disabled due to the rubella epidemic of the mid-1960s, and prepare them for independence and employment, $5.3 million is the minimum funding level needed for FY 1989. This contrasts with the FY 1988 appropriation of $4.8 million; level funding is proposed in the President's budget. Also of great interest to ALL and other organizations of and for the blind is the program which supports the training of rehabilitation professionals, among them university programs in orientation and mobility and rehabilitation teaching for the blind. Some $850,000 annually is allocated for training support in these disciplines. The total RSA training appropriation in FY 1988 was $30.0 million, the same amount provided fifteen years ago. The President's budget also includes $30 million for this purpose; we join other coalitions in recommending a total of $35 million in FY 1989 to sustain this important program, including the training of blindness professionals.

Office of Special Education Programs .

The Office of Special Education Programs(OSEP) funds provide partial support for residential schools for the blind, which ALL and its members strongly endorse as a necessary option in the statutorily mandated continuum of services for blind and visually impaired children. State-operated programs are funded under Public Law 89-313, including residential schools for the blind. These programs were funded at $151.26 in FY 1988. Because of inflation, we concur in the recommendations of the Consortium for Citizens with Developmental Disabilities that this program should receive an appropriation of $167 million in FY 1989. As indicated in the report of the Commission on Education of the Deaf, the current philosophy of special education has inappropriately emphasized the "least restrictive environment" over individual needs. The situation with blind children is much the same as with deaf children, and we believe the Commission's report in this regard applies with equal force to the blind. Residential environments are appropriate and necessary in the case of some children; others may do well in a public school situation, or a combination of public and specialized programs. Under the President's budget the deaf-blind centers program is proposed to be merged with the severely handicapped program. The rubella bulge of the mid-1960s was not followed by an end to deaf and blind children, and there is a continuing need for services to this population. A merger of the two programs would not serve either deaf-blind or severely handicapped populations well. Personnel preparation in special education does not categorize by type of disability. As in rehabilitation, however, there is a growing shortage of vision teachers. There is a great need for federal support to train such specialists.

The American Printing House for the Blind(APHB) is an institution of great importance to blind and severely visually impaired persons. The appropriation for APHB has remained essentially level for a number of years. The per capita level of support for materials for the visually impaired has decreased from $180 in 1980 to $109 today, and the annual cost for such materials is $749. In FY 1988 $5.5 million was appropriated for APHB. We believe an appropriation for FY 1989 of $6.0 million for the American Printing House for the Blind would be eminently reasonable.

State Grants for Special Education and Rehabilitation should be funded at levels recommended by other coalitions.

STATEMENT OF JOHN E.D. BALL, PRESIDENT, NATIONAL CAPTIONING INSTITUTE

Senator WEICKER. Mr. John E.D. Ball, president, National Captioning Institute.

Mr. BALL. Thank you, Senator.

The National Captioning Institute appreciates this opportunity to submit testimony in support of the fiscal year 1989 budget needs of the Media Services and Adaptation Branch of the U.S. Department of Education. NCI is a section 501(c)(3) nonprofit organization now in its ninth year of operation. NCI provides television captioning services for hearing-impaired persons with both public and private support. In addition, we promote the unique line 21 closed caption television service. The line 21 technology is the de facto standard in North America for the delivery of caption. It is fully compatible with the television standards common to broadcasters, cablecasters, and the home-video industry. The service requires the viewer to purchase a decoder and attach it to his or her TV set in order to see the captions.

Very quickly, Mr. Chairman, because of the time constraints, let me indicate that NCI believes that the funding level set by the Congress for the captioning of national and local programming should be increased to $7.5 million annually. Daytime programming and additional support for local news captioning services should be targeted for this increased funding. NCI also recommends continued funding of current programming initiatives in the area of news, children's programming, syndication, sports, and movies.

Federal support of decoder development and subsidy has enabled NCI to continue producing a consumer product that is ever more affordable to hearing-impaired families. We are moving we think with congressional help toward that. I have brought along this little device just to show you. This is the newest device that will also enjoy a government subsidy. This is the much smaller, more portable unit that will be available starting this month.

Senator WEICKER. And what does that plug into?

Mr. BALL. It plugs into any TV set or cable converter.

Senator WEICKER. And that is very simple for the person to connect?

Mr. BALL. It is very simple. It has got two connectors. It is as simple as one can make an external device.

At the same time we are, thanks to congressional support, this is the brains of that unit that fits inside, and we are hoping within the next year to see it drop to about this size. When we do that, two things will happen. One, the price will come down.

This thing costs about $35, $40 to manufacture. This device or a device of this size will cost we hope about $10 to $15. The size also will allow it to be built into TV sets. We are seeing increasing interest on the part of the manufacturers to build them into the TV set.

So we are making and we make recommendations on increased public awareness with regards to the service so that we will see a great demand for it because we think the key to the future of the service is that increased demand on the part of the deaf.

All too many deaf children do not have decoders. We are recommending that funds that were previously used on a basis to subsidize all units be used to help deaf kids get decoders. We found out in a recent survey that in some schools, as many as 90 percent of the deaf children do not have this device, despite the educational value.

PREPARED STATEMENT

That is my testimony. Thank you, Mr. Chairman.

Senator WEICKER. Mr. Ball, thank you very much. Thank you very much.

[The statement follows:]

STATEMENT OF JOHN E.D. BALL

The National Captioning Institute (NCI) appreciates this opportunity to submit testimony in support of the FY 1989 budget needs of the Media Services and Adaptation Branch of the U.S. Department of Education. NCI is a Section 501 (c) (3) nonprofit organization now in its ninth year of operation. NCI provides television captioning services for hearing-impaired persons with both public and private sector support. In addition, NCI promotes the unique Line 21 closed captioned television service, and strives to ensure that all who could benefit from the service are given the opportunity to do so. The Line 21 technology is the defacto standard in North America for the delivery of captions. It is fully compatible with the television standards common to broadcasters, cablecasters, and the home video industry. The service requires the viewer to purchase a "decoder" and attach it to his or her TV set in order to see the captions.

Since NCI submitted testimony last year, there have been encouraging developments in the amount and diversity of captioned programs; the availability of decoders; and the participation of the private sector in the provision of the service.

Perhaps of greatest significance has been the submission to Congress of the report of the Commission on Education of the Deaf. That landmark documents calls for many improvements in a broad spectrum of activities and services provided to hearing-impaired Americans. In its deliberations, the Commission thoroughly examined the closed-captioned television service and, throughout its year-long examination of these issues, provided ample opportunity for many different viewpoints, including those of NCI, to be presented. We believe the Commission's recommendations accurately reflect the opinion of hearing-impaired persons that captioned television is a vital aspect of their daily lives and needs and should be expanded to include all television programming, and be available to all hearing-handicapped citizens. As one hearing-impaired person observed in regard to television programs, "captions are as essential to a hearing-impaired person as sounds are to a hearing person."

Inherent in the Commission's report and its recommendations is the need for a greater Federal role in establishing an affirmative action plan that will lead to more widespread captioning of broadcast and cablecast TV programs, as well as those video materials produced with Federal funds, including those presented in public places. Additionally, the Commission stressed the need for the availability of TV sets with caption decoding circuitry built in by the TV set manufacturer. Our testimony here reflects recommendations NCI made to the Commission. What NCI proposes today is a well structured, well coordinated action plan directed by the Federal government that will ensure that hearing-impaired people will have full access to all television services within the next few years.

CAPTIONED PROGRAM DEVELOPMENTS

The number of hours of closed-captioned programming available on broadcast TV, cable TV, and home video has increased by almost 50% since NCI's testimony last year. These increases have resulted from increased funding from the private sector as well as from the Department of Education.

Capital Cities, Inc./ ABC and the Public Broadcasting Service continue their generous tradition of supporting captioning costs. The entire ABC prime time schedule is now captioned as are many PBS adult and children's programs.

The CBS network has adopted a policy similar to that of NBC of agreeing to pay for one-third of the captioning costs for their programs if matching contributions were provided to cover the balance of costs. As a result of these policies, almost 80% of all prime time programming on the three major commercial networks is now captioned, a significant increase over the 66% of the previous year. Television program syndicators have also begun to pay for the captioning of their shows. Most notably, WHEEL OF FORTUNE, JEOPARDY, and THE OPRAH WINFREY SHOW are now captioned with full private sector support. NCI has been able to secure private sector funding to caption both the Winter and Summer Olympics in 1988, a total private sector funding commitment which provides nearly 200 captioned hours of captioned Olympics coverage.

Through new initiatives of the Department of Education, captioned news and public affairs programming has increased dramatically over the past year. Grant funding has allowed NCI to simultaneously caption all three network week night evening news broadcasts for the first time. A shared funding arrangement with CBS allows NCI to caption that network's weekend news program as well.

Other funding from DOED will enable NCI to caption 50% more children's TV programs this year. Among these programs are SESAME STREET, MR. ROGERS' NEIGHBORHOOD, and many other PBS, commercial network, and syndicated programs.

DOED is also stimulating the growth of captioning at the local TV station level by funding projects to initiate closed-captioning local news services across the country. NCI was awarded such a grant to assist KGTV, the ABC affiliate in San Diego, start captioning its local news programs. The Department recently announced that it would fund ten additional local news captioning projects during this fiscal year. In each case, the Federal funds are to be matched with private sector funds, and at the expiration of the three-year grant period, the local station is to find private sector funding for continued captioning. Many more TV stations want to provide this service to hearing-impaired viewers in their communities.

FUNDING RECOMMENDATIONS

NCI believes that the funding level set by the Congress for the captioning of national and local programming should be increased to $7.5 million annually. **Daytime programming and additional support for local news captioning services** should be targeted for this increased funding.

NCI recommends that **$1 million** be appropriated and specifically earmarked to assist the development and growth of **captioned daytime television programs**, for which private sector captioning sponsorship has been difficult to obtain. Elderly persons at home during the day would be primary beneficiaries of this service. In addition, Congress should consider appropriating and specifically earmarking **$1 million** of these funds (an increase of $0.5 million) for **local news captioning services** to encourage TV stations to caption local TV programming. Government start up funds applied to initiate captioning of local news programming will lead to greater private sector support which eventually would sustain the service at the expiration of the government grant period. Department of Education funding assistance of this kind will encourage local TV stations to investigate and implement new technologies that will provide captioning services at little or no on-going cost to the TV station. NCI believes that with a sustained effort, this initiative would lead to captioning of local news programs in virtually every TV market within a few years.

NCI also recommends **continued** funding of current programming initiatives in the areas of **news, children's programming, syndication, sports, and movies.**

DECODER DISTRIBUTION DEVELOPMENTS

Federal support of decoder development and subsidy has enabled NCI to continue producing a consumer product that is ever-more affordable to hearing-impaired families. As a result of this, the audience receiving the captioning service continues to grow. The funding that Congress appropriated in FY 1987 has resulted in the development of a smaller, lower cost decoder, the TeleCaption 3000, that will be introduced for retail purchase in June 1988.

The Commission on Education of the Deaf has recommended that decoders be built into TV sets, in addition to the widespread availability of decoders to hearing-impaired persons who can not afford the current decoder price. The methods for achieving these goals are linked together.

Continued funding of development of the technology will lead to a smaller, lower-priced, and multi-purpose captioning module being manufactured. (The module is the internal piece of hardware circuitry that "decodes" the captions.) Such a module could be built into TV sets at a very small incremental cost to the consumer. This same module could be built into other products, such as a lower priced external decoder, a tunerless decoder (for VCR/cable converter applications), and into VCRs also.

Federal *development* funds should continue to be available to refine, enhance and improve the decoder technology. NCI recommends that federal support funds be made available to support this technology development work. A successful decoder development would have three major facets to it:

- future decoders would be compatible with prior generations of decoders;
- all decoders would be compatible with the evolving television technologies such as cable TV scrambling systems, TV program time compression systems, and home video anti-duplication devices; and
- future decoders would incorporate the latest technological innovations in order to minimize their cost of manufacture, provide additional features and facilitate their incorporation into TV sets, VCRs, etc.

A well managed, federally supported program is essential to ensure that ongoing compatibility in decoders is achieved. Examples of private sector technology development yielding incompatible products include the video cassette recorder industry (VHS vs. Beta formats), and the teletext technology, which has evolved into two incompatible systems (WST vs. NABTS). The closed-captioning service can ill afford this type of conflict which could leave thousands of hearing-impaired persons with incompatible decoders. NCI estimates that the hearing-impaired population has invested almost $60 million in decoders. Federal involvement in technology development will protect that investment.

The Commission on Education of the Deaf report cites the testimony of ABC, NBC and others in its recognition that **the captioning service can become a truly self-sustaining and viable part of the television industry only when the size of the market - those homes that have decoders - reaches a critical mass.**

Presently, Federal funds appropriated by the Congress are used to lower the cost of decoders. NCI supports the Commission's concept of using Federal *subsidy* funds to help broaden the distribution of decoders. There are persons who would never be able to afford a decoder regardless of its cost. NCI wholeheartedly endorses the Commission's recommendation that decoders should be distributed to all hearing-impaired persons who cannot afford to purchase them. NCI has initiated successful programs which have raised private funds to provide decoders at a reduced price to low-income families. One program is DARE (Decoders Advance Reading and Education). This program is designed to make decoders available for $35 to hearing-impaired children of low income parents. NCI actively seeks contributions from corporations and foundations to underwrite most of a decoder's cost. Another project is ACCESS (American Corporations Can Enhance Success for Seniors). This program makes decoders available for only $10 to senior citizens of limited fixed income. NCI is proud that to date, almost 2,000 decoders have been made available through these programs.

FUNDING RECOMMENDATIONS

NCI recommends that the Federal government continue to fund decoder subsidy activities at an annual level of $1.5 million. Federal support for research to refine and further develop the captioning technology is recommended at the $0.5 million level to ensure the development of a small and low cost decoder module that can be easily incorporated into television sets at little pass-along cost to the consumers.

The emphasis of the subsidy activities should be shifted to ensure that persons who cannot afford to purchase a decoder at regular price have the opportunity to obtain one at little or no cost. In addition, a priority should be placed on providing decoders to all hearing-impaired children. A plan could be developed and implemented that would provide decoders to this group over a several year period. For instance, at a subsidy funding level of $1.5 million, decoders could be distributed to hearing-impaired learners and others under a long-term loan program managed through schools and other means. The Commission's report indicates that there were 36,000 deaf students in the United States in 1985-86. (Final Report, Page 10) At the recommended funding level, every hearing-impaired student would receive a decoder within a four-year period. After that, the incremental cost of maintaining the program for new students entering school programs would be minimal. In addition, the reliability of the decoder virtually guarantees that students will enjoy full use of their decoders for the life of their school experience.

The Department of Education has not yet provided continued funding for decoder activities for FY 1988, as appropriated by Congress. NCI believes that DOED should release these funds, so that continued efforts to provide low cost decoders to hearing-impaired persons will not be imperiled.

OTHER ACTIVITIES

Public Awareness and Public Education

The Department of Education recently awarded a two-year contract for activities related to increasing public awareness about captioning. While this award is a beginning, NCI urges that a more aggressive program be initiated with Federal support to ensure that the many persons in the United States who could benefit from the captioning service are made aware of the availability of captioned TV programs and the decoder device. Among the populations which should be targeted are the elderly, persons with reading and learning problems, and persons learning English as a second language.

In addition, specific activities should be focused towards the television industry to make its leaders aware of emerging technologies which can make the provision of captioning services less costly to initiate and maintain. In addition, the TV industry needs to be made aware of the large segments of their audiences which can benefit from the captioning service.

Ongoing Research

Over the past eight years, NCI has initiated several research studies into the effectiveness of captioned television as an educational tool. NCI believes that Federal support for wide-ranging additional research into caption readability and the measurement of its effect on the acquisition of reading skills is desirable and necessary. With the audience for the captioning service steadily increasing, and the availability of increased captioned programming for children, additional research should be undertaken that will lead to improved captioning standards and techniques.

FUNDING RECOMMENDATIONS

An aggressive public awareness and public education initiative designed to reach those potential audiences that are as yet untapped beneficiaries of the captioning service should be funded at the **$ 1 million level.**

On-going research into caption readability and the effect of captioning on reading should be funded at the **$0.5 million level.**

SUMMARY OF RECOMMENDED FY 1989 FUNDING LEVELS

National Captioned Programming -	$ 6.5 million
Local Captioned Programming -	$ 1.0 million
Decoder Subsidy Program -	$ 1.5 million
Decoder Technology Development -	$ 0.5 million
Public Awareness and Education -	$ 1.0 million
Basic and Applied Research -	$ 0.5 million
TOTAL	$11.0 million

NCI believes the above are critical funding areas that fit the leadership role that Congress has played in the development and growth of the closed captioned television service.NCI wishes to express its sincere appreciation for the confidence that Congress and the Department of Education have shown in giving NCI such a crucial role to play in the development of so vital a service for so many previously ignored hearing-impaired persons.

Thank you for this opportunity to submit this testimony.

STATEMENT OF BERNARD GOULD, MEMBER, GOVERNMENTAL AFFAIRS COMMITTEE, ASSOCIATION FOR RETARDED CITIZENS OF THE UNITED STATES

Senator **Weicker**. Our next witness is Bernard Gould of the Association for Retarded Citizens [ARC] of the United States.

Mr. **Gould**. Thank you, Mr. Chairman.

The ARC, as I think you know, is an organization of about 160,000 members throughout the United States. Most of them are the parents of children with mental retardation.

In 1986 Congress enacted two laws which, when fully funded and implemented, will drastically reduce the dependency of many children and adults with mental retardation on costly future services and benefits and will hopefully turn them instead into productive members of our society. I am, of course, referring to the Education of the Handicapped Amendments and the Rehabilitation Act Amendments.

As to special education, Congress restructured the Federal Government's role in funding preschool education for 3- to 5-year-olds with handicaps, creating a mandate for all those children to be served by school year 1990–91. It is vital that the Congress fully fund the preschool program under EHA at the fully authorized amount. Unless it does so, many eligible children will not gain timely access to needed educational services since the law delays that mandate to the 1991–92 school year.

There are over 30,000 preschoolers with disabilities who are now being served, and another 31,000 who would be served next year, but only if the program is fully funded.

Congress also authorized a totally new and very exciting program to serve infants and toddlers with disabilities from their birth to age 3. This early intervention program has great promise to maximize each child's developmental progress and significantly reduce the need for future services throughout his or her life.

It also helps the parents of those newborns to understand and cope with their infant who is born with some disability.

Some States have warned that they will not enter this program if they see that the Congress is not meeting its fiscal promise. An appropriation of $85 million will reflect the Congress's support and hopefully bring all of those States into the program.

As to adults with disabilities, the Rehabilitation Act authorized a new State grant program called supported employment which assists individuals with severe handicaps to enter a competitive working environment with the necessary support services. It has proved to be very successful in employing people with severe mental retardation.

Without support such as a job coach, these individuals would likely never have the opportunity to enter the work force. That program should be fully funded at a modest $28 million.

I would also like to call your attention to the Education of the Handicapped and the Vocational Rehabilitation State Grant Program which are extremely important in educating and training people with handicaps.

Although promised a 40-percent reimbursement when Congress enacted the special education law, schools are now receiving only a 10-percent reimbursement. We recommend Congress fund this program at a conservative 15-percent level by an appropriation of $2.148 billion.

There are approximately 40,000 people with mental retardation successfully rehabilitated each year by the Vocational Rehab State Grant Program. Even so, there are thousands of individuals who are mentally retarded and are denied access to vocational rehab services, not because they cannot be trained to work, but simply because there are not sufficient funds.

Without that help, the mentally retarded person remains a dependent, frustrated individual who must survive on costly Federal handouts such as SSI or other welfare type benefits.

We strongly urge you to increase the State vocational rehab funding by an appropriation of $1.55 billion.

I notice that my time is up, Mr. Chairman. I would only like to refer you to the chart which is attached to my written statement which lists a number of other programs with which we are vitally concerned, and the appropriations which we consider appropriate.

[The statement follows:]

STATEMENT OF BERNARD GOULD

Mr. Chairman, it is a pleasure and an honor to appear before you today on behalf of the Association for Retarded Citizens (ARC), an organization of 160,000 members throughout the United States, most of them parents of children and adults with mental retardation, dedicated to the continuing task of improving the quality of life of all persons with mental retardation.

The ARC is most keenly aware of the vital role you have played in protecting programs serving persons with mental retardation from huge reductions and terminations proposed by the Administration in the past. We thank you for your diligence and your unbending advocacy on behalf of our nation's citizens with mental retardation and other disabilities. Although we are not facing drastic cuts this year, our needs are no less critical and we again request your assistance.

In regards to the FY 1989 appropriations for programs most critical to persons with mental retardation, we can simply say keep up your outstanding efforts. In 1986, the Congress enacted two laws which, when fully funded and implemented, will drastically reduce the dependency of many children and adults with mental retardation on costly future services and benefits and turn them instead into productive members of our society. These two laws are the Education of the Handicapped Amendments and the Rehabilitation Act Amendments of 1986.

In the area of special education, the Congress has restructured the federal government's role in funding preschool education for 3 to 5 year olds with handicaps, creating a mandate for all such children to be served by school year 1990-1991. It is vital that the Congress fully fund the Preschool Program under EHA at the fully authorized amount. An appropriation of $275 million is needed to fully fund the program. If the Congress does not fully fund this program, many eligible children will not gain access to needed educational services since the law delays the mandate for 1 year to the 1991-1992 school year. Over 30,000 additional preschoolers with disabilities are being served this year and another 31,000 are expected to be served next year. This will only happen if this program is fully funded. For many of us, waiting another year for something may not be critical, but for the 3 year old youngster with handicaps, such a delay is crucial and the opportunity for rapid development is lost forever.

In the same law, the Congress also authorized a totally new, very exciting program to serve infants and toddlers with disabilities or at risk of being disabled from the time they are born until they reach 3 years old. This Early Intervention Program holds fantastic promise, supported by much new research data, to maximize each child's developmental progress and again, significantly reduce the need for future services throughout life. Further, this program is aimed at helping the parents of these newborns to understand and cope with their infant born with disabilities. Some states have warned that they will not enter this optional program if they see the Congress not meeting their fiscal promise. An appropriation of $85 million will reflect the Congress' support for this program and hopefully, bring every state into the program.

Turning your attention to adults with disabilities, the Rehabilitation Act has authorized a new state grant program called Supported Employment. This program assists individuals with severe handicaps, most of them mentally retarded, to enter the world of work in a competitive environment with the necessary support services. Supported Employment, while a relatively new concept in employment, has proven very successful in employing persons with severe mental retardation. Without supports such as job coaches, these individuals would likely never have the opportunity to enter the work force and become productive, tax paying members of our society. This modest program should be fully funded at $28.06 million, which represents only a $2 million over current funding.

In regards to the other priority programs of importance to citizens with mental retardation and their families, we call your attention to the Education for the Handicapped State Grant and Vocational Rehabilitation State Grant programs. These two programs, administered by the Department of Education, play vital roles in educating and training our citizenry with handicaps. Almost 750,000 school age children with mental retardation profit each year from special education in our nation's schools. Since educating children with handicaps is expensive, we recognize the major role the federal government plays through P.L.94-142 funding in assisting local school systems. Although the Congress promised the schools a 40% reimbursement when it enacted the landmark special education law, schools are now receiving only a 10% reimbursement. We recommend the Congress fund this program at the 15% level as soon as possible. This would be accomplished by providing an appropriation of $2.148 billion.

Approximately 40,000 persons with mental retardation are successfully rehabilitated each year by the Vocational Rehabilitation State Grant Program. Despite this very impressive statistic, thousands of individuals who are mentally retarded are denied access to vocational rehabilitation services annually, not because they cannot be trained to work but simply because there are insufficient funds. The alternative to a trained, employable individual with mental retardation is a dependent, frustrated individual who must survive on costly federal benefits such as Supplemental Security Income (SSI) or other welfare type benefits. The ARC strongly urges the Congress to increase the State Vocational Rehabilitation funding to serve the many individuals with mental retardation and other handicaps who are waiting to be trained for jobs. We recommend an appropriation of $1.55 billion for this program.

Mr. Chairman, since the needs of persons with mental retardation are lifelong, many other federal programs that I do not have the time to review today also need your attention and support. Very important are funding increases for the Maternal and Child Health Block Grant, the Title XX Social Services Block Grant and the programs within the Developmental Disabilities Act. We have attached a chart of the many other federal programs which impact on the lives of children and adults with mental retardation and their families. We sincerely hope the Congress sees fit to fund these programs at the recommended amounts. Again, Mr. Chairman, we thank you and members of this Subcommittee for your strong support in the past and we hope you will again allow our programs to expand.

Summary Table

	FY 1987 Appropriation	FY 1988 Appropriation	FY 1989 Authorization	President's FY 1989 Request	ARC FY 1989 Recommendation
			(in millions)		
DEVELOPMENTAL DISABILITIES PROGRAMS					
DD Basic State Grant	56.500	58.401	69.900	58.401	69.900
DD Protection and Advocacy Systems	15.500	19.148	22.000	19.148	22.000
DD University Affiliated Programs	9.187	12.446	15.200	12.446	15.200
DD Grants of National Significance	2.800	2.872	3.650	2,872	3.650
EDUCATION OF CHILDREN WITH HANDICAPS					
State and Local Grant Programs (P.L. 94-142)	1,338.000	1,431.737	Formula	1,474.239	2,148.660
Preschool Grants	180.000	201.054	259.440	205.075	274.950
Early Infant Intervention Program	50.000	67.018	Such Sums	68.358	85.000
Early Education for Handicapped Children	24.470	23.428	27.410	23.428	27.410
Secondary Education and Transitional Services	7.300	7.372	8.100	7.372	8.100
Postsecondary Education Programs	5.900	5.840	6.600	5.840	6.600
Special Education Personnel Development	67.730	66.410	79.000	66.410	79.000
Special Education Technology	4.696	4.787	11.025	4.787	11.025
State Operated Programs (P.L. 89-313)	150.170	151.260	Formula	151.260	167.000
Vocational Education	815.000	804.216	Such Sums	848.333	848.333
REHABILITATION SERVICES					
Vocational Rehabilitation State Grants	1,281.000	1,379.500	1,550.010	1,407.090	1,550.000
Supported Employment Services	25.000	25.935	28.060	26.454	28.060
Rehabilitation Training	29.550	30.000	35.000	30.000	35.000
Comprehensive State Services for Independent Living - Part A	11.830	12.310	13.050	12.556	13.050
Centers for Independent Living - Part B	24.320	25.500	27.300	25.500	27.300
Independent Living Services for Older Blind Persons - Part C	5.290	5.600	5.930	5.600	5.930
Protection and Advocacy - Part D	0.000	0.000	Such Sums	0.000	10.000
Special Demonstration Programs	27.400	27.900	28.300	27.900	28.300
Projects with Industry	16.070	17.000	18.030	17.000	18.030
Special Recreation Programs	2.330	2.470	2.620	0.000	2.620
Client Assistance Programs	7.100	7.500	8.000	7.650	8.000
National Institute on Disability and Rehabilitation Research	49.000	51.100	55.000	51.100	55.000
BLOCK GRANT PROGRAMS					
Title XX Social Services Block Grant	2,700.000	2,700.000	2,700.000	2,700.000	3,000.000
Maternal and Child Health Block Grant	496.750	526.570	561.000	561.000	561.000
Maternal and Child Health Special Projects (SPRANS)	71.700	78.400	84.100	52.600	84.100
Alcohol, Drug Abuse and Mental Health Block Grant	508.860	487.317	Pending	509.000	601.500
Services to Homeless Individuals Who Are Seriously Mentally Ill	32.200	11.500	Pending	14.300	100.000
PREVENTION PROGRAMS					
Women's Infants' and Children's Feeding Program	1,663.500	1,802.363	Such Sums	1,871.972	2,021.972
Immunization Program	95.750	98.247	Pending	101.751	136.620
Retroactive Vaccine Injury Program	*	*	80.000	0.000	80.000
Pediatric AIDS - MCH Block Grant & NICHD	*	10.000	**	11.900	15.000

BIOMEDICAL AND BEHAVORIAL RESEARCH	FY 1987 Appropriation	FY 1988 Appropriation	FY 1989 Authorization	President's FY 1989 Request	ARC FY 1989 Recommendation
Natl Insti. of Child Health and Human Development	366.780	396.811	Such Sums	418.388	568.425
Natl Insti. of Neurology & Comm. Disorders & Stroke	490.233	534.692	Such Sums	570.978	704.500
National Institute of Mental Health Research	235.400	254.000	Such Sums	269.000	400.000
NIMR Research Training	19.000	19.000	Such Sums	19.900	27.000
NIMR Clinical Training	15.000	16.700	Such Sums	10.000	26.000
SPECIAL CONCERNS					
Architectural and Transportation Barriers Compliance Board	1.890	1.891	3.000	2.000	2.200
Child Welfare Services (Title IV-B of the SSA)	222.500	239.350	266.000	239.350	266.000
Committee for Purchase from the Blind and Severely Handicapped	.670	.850	.860	.860	1.000
Comprehensive Planning for Seriously Mentally Ill Individuals	*	4.000	10.000	0.000	10.000
Foster Grandparents Program	53.700	56.100	58.700	57.400	58.700
Job Training Partnership Act Block Grant	1,840.000	1,809.500	Such Sums	1,809.500	1,881.400
JTPA Pilots and Demonstrations	31.600	39.000	Such Sums	31.600	40.600
Legal Services Corporation	305.500	305.500	Pending	250.000	393.000
Mental Health Services Demonstration	15.000	19.100	Pending	30.900	34.500
National Council on the Handicapped	.860	.892	.974	.974	.974
Project Head Start	1,131.000	1,206.000	1,332.000	1,206.000	1,332.000
Protection and Advocacy for Persons with Mental Illness	10.500	10.555	Pending	8.000	22.000
Small Business Administration - Handicapped Assistance Loan Program	15.000	13.000	20.000	0.000	20.000
Temporary Child Care for Children with Handicaps and Chronic Illnesses	0.000	4.787	Pending	5.000	20.000
Transportation Services -					
Rural and Small Community Transit Grants	75.000	64.600	Formula	67.000	75.000
Rural Transit Assistance Program	0.000	4.800	5.000	0.000	5.000
Urban Mass Transit Grants	1,925.000	1,732.300	Formula	1,214.500	1,841.600
Vehicle Purchase	35.000	35.000	35.000	35.000	38.500
HOUSING PROGRAMS					
Section 202 Direct Loan Program	507.000	555.800	630.000	350.100	630.000
Supportive Housing Demonstration Program	85.000	64.300	Pending	75.000	140.000
Congregate Housing Services	3.400	4.200	10.000	0.000	10.000
Community Development Block Grant	3,000.000	2,880.000	3,000.000	2,480.000	3,000.000

ENTITLEMENT PROGRAMS	FY 1987 Actual	FY 1988 Estimated	FY 1989 Proposed Budget	
			Current Law	Proposed Outlays
Social Security Disability Insurance	20,421.000	21,404.000	22,373.000	22,373.000
Supplemental Security Income	9,900.000	11,397.000	11,368.000	11,368.000
Medicare - Client Benefits	79,789.000	85,584.000	93,329.000	93,014.000
Medicare - Total	81,645.000	87,657.000	95,808.000	94,491.000
Medicaid - Client Benefits	26,032.000	29,070.000	31,481.000	31,068.000
Medicaid - Total	27,435.000	30,664.000	33,141.000	32,733.000
Food Stamps	11,793.000	12,639.000	12,519.000	12,519.000
Foster Care	764.000	703.000	Pending	941.000
Adoption Assistance	59.900	108.000	Pending	133.000

FOOT NOTES:

* initial authorization of the program had not occurred

** the authorization for Pediatric AIDS is contained within the existing statutory authorities for the Maternal and Child Health Block Grant and the National Institute for Child Health and Human Development

Senator **Weicker**. Mr. Gould, thank you very much.

I admire greatly your organization, all those that work within it as professionals, as parents, as volunteers. The Association for Retarded Citizens does great work.

Mr. **Gould**. Thank you very much.

Senator **Weicker**. I know in my State of Connecticut, my home town of Greenwich.

Mr. **Gould**. Thank you for all the help that you have given us in our program.

Senator **Weicker**. You do a great job, a great job. Thank you.

STATEMENT OF DOTTIE VANKEVICH, BOARD MEMBER AND VOLUNTEER, UNITED CEREBRAL PALSY OF MONTGOMERY COUNTY, MD, ON BEHALF OF UNITED CEREBRAL PALSY ASSOCIATION

Senator **Weicker**. The next witness is Patricia Brady of the United Cerebral Palsy Association.

Ms. **Vankevich**. Good morning. My name is Dottie Vankevich. I am a board member and a volunteer at United Cerebral Palsy of Montgomery County, MD, and I am a parent of a child with cerebral palsy. I am here today on behalf of United Cerebral Palsy Association [UCPA]. UCPA is a national network of community based services for persons with disabilities. It has more than 180 affiliates in 45 States. Collectively, UCPA spends over $300 million a year on a broad range of services for children and adults with severe disabilities.

I would like to submit a formal statement for the record and use this time to tell you about a few very important programs for individuals with developmental disabilities.

Now in its second year, part C of title VI, supportive employment for individuals with severe disabilities, is for many the only link between school and competitive employment. Supportive employment was used as a strategy for employing Roger Austin from Birmingham, AL, who became severely physically impaired following an auto accident.

Despite numerous assessments and 7 years with an open case with VR, he was never hired. In fact, Roger was told that his desire to become a computer operator was not a reasonable vocational goal, despite the fact that he used one daily at home.

When his supportive employment specialist discovered his desire to have a job using computers, she negotiated a job for him in a printing business. Roger is now working 25 hours a week as a data input clerk. The difference for Roger has been that supportive employment assumes a readiness to work and an ability to learn the necessary skills, rather than testing him with traditional vocational assessments to determine what he cannot do.

Roger is like thousands of others who are ready to work if we are ready to provide the necessary training, technology and support.

Therefore, USCPA recommends funding part C of title VI at the full authorization level of $28 million.

Independent living, part A and part B of title VII of the Rehabilitation Act, supports independent living for individuals whose disabilities are severe but who could not live independently in the community. UCPA requests funding the full authorizations for parts A and B of title VII. To support our position, I would like to tell you about Darwin Maguire who works for the secretary of Wisconsin Health and Social Services.

Not only is he a great worker, but he has the kind of upbeat personality that rubs off on others and makes it a better place to work. Darwin happens to have brown hair, blue eyes and cerebral palsy. None of these characteristics prevent him from having a rich, full life in his community; yet, until 2 years ago when he was able to move to an accessible apartment in Madison, Darwin had spent 47 years in a State institution.

Currently, over 40,000 individuals are served by 170 independent living centers which, in turn, are supported by 125 Federal grants. However, the National Council on the Handicapped estimates that there are over 400,000 citizens that could benefit from independent living programs.

In establishing part H of the Education of the Handicapped Act, Congress recognizes the extreme importance as well as the cost effectiveness of early intervention for infants who are developmentally delayed. Although participation in this program is voluntary, at present, all States have responded to Congress' lead and have early intervention programs, programs like UCP of Orange County, CA, bilingual infant development program where families learn how to be teachers to help their developmentally delayed youngsters.

PREPARED STATEMENT

For the past 2 years, Socorro Ventura has spent 6 hours a week at the program, ever since her son Miguel was born with Downs syndrome. When Miguel first arrived, he was months behind, but after a year in the program he was doing much—he was not only walking but doing many more age appropriate activities.

I would like to note that my time is up and submit the rest of my formal statement.

[The statement follows:]

STATEMENT OF DOTTIE VANKEVICH

I am here today on behalf of United Cerebral Palsy Associations. UCPA, a national network of community-based services for persons with disabilities, has more than 180 affiliates in 45 states. Collectively, UCPA spends over $300 million a year on a broad range of services for children and adults with severe disabilities.

I am here to ask your support and funding for programs essential to ensure that individuals with severe disabilities have access to education, employment, and independent living programs; that infants and toddlers have access to early intervention programs; and that families have access to other community-based, cost-effective services such as respite care. I urge the committee to support the UCPA recommendations for funding for four basic state grant programs—Part B of P.L. 94-142 Education of Children with Handicaps; Title I of the Vocational Rehabilitation Act; Title IIA of the Job Training Partnership Act; and finally, Part B of the Developmental Disabilities Act. I want to use the time allotted me, however, to tell you a little about the impact that a few critical programs have on the lives of individuals with developmental disabilities.

SUPPORTED EMPLOYMENT Now in its second year, Part C of Title VI—supported employment for individuals with severe disabilities—is, for many, the only link between school and competitive employment. For many, it is an effective response to a dependent life style. The program holds great promise for securing appropriate employment for individuals who were previously not considered capable of working and of being taxpayers. I want to tell you about Roger Austin from Birmingham, Alabama who became severely physically impaired following an auto accident. After numerous assessments and seven years with an open case with VR, he was never employed. Roger was told by his counselor that his desire to become a computer operator was not a reasonable vocational goal, despite the fact that he had a home computer which he used daily. Supported employment was used as a strategy for employing Roger. His employment specialist discovered his desire to have a job using computers, and she negotiated a job for him in the printing business. Roger is now working 25 hours a week as a data input clerk in a printing company. The difference for Roger has been that supported employment assumes readiness to work and ability to learn necessary skills rather than testing him with traditional vocational assessments to determine what he cannot do. Roger is like thousands of others who are ready to work — if we are ready to provide the necessary training, technology and supports.

Through supported employment, state VR agencies are serving individuals never before eligible for services for lengths of time that are frequently longer than the traditional VR client. Supported employment is possible through the establishment of cooperative agreements with other departments and agencies such as developmental disabilities, mental health, mental retardation and other funding sources. These funding sources are paramount for successful outcomes.

For FY1989, the President proposes only a modest increase in Part C of Title VI. Given inflation, this will result in a reduction in the number of individuals served and make it difficult for state agencies to develop the collaborative agreements necessary to maintain employment and hold down costs to the VR agency. UCPA recommends funding at the full authorization level of $28 million to support employment opportunities for individuals with severe disabilities that have never had the opportunity to work in competitive employment.

INDEPENDENT LIVING Part A and Part B of Title VII of the Rehabilitation Act support the opportunity for independent living for individuals whose disabilities are severe but who can live independently in the community.

I would like to tell you about Darwin McGuire who works for the Secretary of the Wisconsin Department of Health and Social Services. Not only is he a good worker, but he has the kind of upbeat personality that rubs off on others and makes the office a better place in which to work. Darwin happens to have brown hair, blue eyes, and cerebral palsy. None of these characteristics prevent him from having a rich and full life in his community; yet until two years ago when he was able to move into an accessible apartment in Madison, Darwin had spent 47 years living in a state institution.

Michael Adams is 26 years old and currently living at home with his mother and three sisters. Because of a diving accident during his adolescent years, Mike is now severely physically impaired. He is also a highly skilled computer operator who is studying at a local community college to obtain a degree. With a goal of independence, he is seeking full-time employment in the field of computer science. He is also seeking housing in an accessible apartment. At the present time, Mike has access to exactly two rooms in his house: his bedroom and his bathroom—and he relies on his mother to take care of his personal, physical needs. Even if Mike succeeds in his goal of finding full-time employment, lack of an accessible apartment plus his need for help with personal needs frustrate his desire for independent living. Within the next few years, Michael's mother will be unable to care for him and he will, in all probability, end up in a nursing home.

Currently, over 40,000 individuals are served by 170 independent living centers which, in turn, are supported by 125 federal grants. However, the National Council on the Handicapped estimates that almost 400,000 citizens could benefit from independent living programs! An extraordinary amount of Medicaid funds are spent on institutions that primarily provide only custodial maintenance for people like Michael and Darwin--in spite of the numerous national and state studies that have demonstrated the community-based options can be provided at a fraction of the cost of facility-based care. Maintenance-oriented institutional care is clearly indefensible for individuals like Michael and Darwin. Whenever possible, the fostering of independence should be supported and the Independent Living programs offer us that opportunity.

UCPA recommends the full appropriation for Parts A and B of Title VI of the Rehabilitation Act.

EARLY INTERVENTION PROGRAMS: In establishing Part H of the Education of the Handicapped Act, Congress recognized the extreme importance--as well as the cost-effectiveness--of early intervention for infants who are developmentally delayed or at risk of developmental delay. Although participation in this program is voluntary, at present, all states have responded to Congress' lead and have early intervention programs and will therefore be providing services to all eligible infants and toddlers at the end of a four-year planning phase. They will do so in programs like UCP of Orange County, California's bi-lingual Infant Development Program where economically disadvantaged families learn "how to be teachers themselves" to help their developmentally delayed youngsters achieve their full potential. For the past two years, Socorro Ventura has spent 6 hours each week at the program, ever since her son Miguel was born with Down's Syndrome. When Miguel first arrived, he was months behind in his development. Socorro hoped that Miguel would eventually learn to walk and to build other developmental abilities. After only one year, Miguel began not only walking but doing more age-appropriate activities. Another parent, Judy Urbanos, has learned in just a few months how much her son Jimmy who is severely disabled and non-verbal enjoys music. Judy points out that the program benefits her in other ways, particularly by helping her share feelings and experiences with parents in similar circumstances.

Unfortunately for children like Miguel and Jimmy, the President has requested an appropriations level for Part H of the Education of the Handicapped Act which is $7 million less than the FY 1988 authorization level. Since several state legislatures, in authorizing legislation for state participation in this program, explicitly conditioned their participation on receipt of adequate federal funding, the President's appropriation's request could mean an end to early intervention. To prevent this, UCPA recommends a funding level of $85 million. An appropriation of $85 million would demonstrate the continued commitment of Congress in assisting states to develop early childhood intervention programs.

TEMPORARY CHILD CARE FOR HANDICAPPED CHILDREN AND CRISIS NURSERIES Title II of the Children's Justice Act, Temporary Child Care for Handicapped Children and Crisis Nurseries, will expire this year. Joint House/Senate hearings are planned for early May to reauthorize the program in time for FY1989 funding. This program authorizes grants to states to provide temporary, non-medical child care for children with disabilities and chronic and terminal illnesses. In addition, the Act provides for grants to provide crisis nurseries for children who are abused.

This respite program is very important to families with a child with disabilities. Let me share with you one family's respite experience. The Maloys, a family in Mobile, Alabama, have a three year old child with developmental disabilities including cerebral palsy, epilepsy, and mental retardation. The child sleeps a total of one hour every night and the parents must sleep in shifts. Since birth, the parents had not been able to leave the child's side to go out together for even routine errands. Immediate family members and relatives would not care for the child for fear of something going wrong. UCP of Mobile offered their respite program on a trial basis. The mother hesitated at first but felt if the sitter would come over and be with the child the night before she planned to go out she would feel better. The following evening, the parents went out for 4 hours. Two months later, the parents were able to go out of town for three days. After three years of living in fear, this is truly remarkable.

In recent studies, respite care was the need most frequently identified by parents of children with disabilities. It is estimated that approximately 10 million children under the age of 21 years have some type of handicapping condition which limits their daily activities. Approximately 96 percent of these children live at home rather than in institutions.

Unfortunately, families with a child with disabilities are about twice as likely to experience divorce or separation. A further concern of UCPA is the alarming link between child abuse and disability. It is well established that respite services have proven to be a cost-effective approach to reducing abuse and in assisting parents to keep their children with disabilities at home.

There is clearly a critical need for federal leadership in recognizing and understanding this problem and to begin to support families who keep their children at home. The President proposes including the program in a consolidated authority for Office of Human Development Services' discretionary research, training and demonstration grant programs at a funding level of only $5 million. This funding level prohibits any expansion of the program, especially since only 17 states have legislation and state appropriations focusing on respite care. UCPA will be asking for a permanent authorization and a first-year funding level of $20 million, and we ask that your committee recommend the full authorization level.

SCHOOL IMPROVEMENT ACT OF 1987 Finally, as you know, House and Senate conferees have agreed on a final bill, H.R. 5, that will extend most federal elementary, secondary and adult education programs. Contained in the bill is a small disability demonstration project to provide for ways to make adaptive technologies, such as alternative communication devices, available to individuals with disabilities. I would like to share with you the story of a child who has already benefitted from the application of technology, a little five-year-old girl named Jessica who is participating in a program at UCP of Nassau County in New York. This little girl is completely non-verbal, with only minimal hand control; yet with the aid of an augmentative communication device, she was able to talk with her mother for the first time. When her mother entered her classroom one day, Jessica began working very hard to beam the light strapped to her head on a specific picture. She was really determined to light up that picture! Once she did, her words were very clear. For the first time ever, that little girl was able to say, "I love you." Unfortunately, Jessica is the exception. For many children and adults with severe physical disabilities, traditional methods of communication and the means to control their environment are not possible, and adaptive technologies and devices like the Touch and Light Talker are still not available to them. UCPA hopes that your committee will recommend full funding for this very important project to make these alternatives more readily available and also seek funding to the full authorization level of Part G-Special Education Technology of the Education of the Handicapped Act which also supports critically needed applied technology demonstration programs.

CONCLUSION In conclusion I wish to emphasize that the funding levels for the programs I have outlined for you today historically receive strong bipartisan support. Whether it be supported employment, independent living or early intervention, each of these programs have proven to be cost-effective investments that enable individuals with severe disabilities to become contributing and valued members of society. UCPA urges your support of our recommendations.

Senator **Bumpers** [presiding]. Thank you very much, and I apologize for getting here a little bit late and not hearing the early part of your testimony.

And it is really most regrettable that we have to run public witnesses through here in such short order because I find I get a lot more from public witnesses information and find myself edified from the people who are out there dealing with these problems.

I must say, the request you make here is a very difficult one, even though I applaud everything you have said, and I certainly like the independent living part of the program that you are involved in. You say there are 400,000 people who could benefit from this, who are not now served.

Ms. **Vankevich**. Yes.

Senator **Bumpers**. How many of those would be served if the money were available?

Ms. **Vankevich**. Since I cannot answer you exactly, I would like to submit the answer to the record later.

Senator **Bumpers**. Well, obviously if it were half of them, it would be a lot, would it not?

Ms. **Vankevich**. Yes.

Senator **Bumpers**. Well, I was speaking at a major university commencement 1 week ago Sunday, and I was sitting beside the president of that university, and he told me that one time he told Ronald Reagan:

> If you really have to have 100 B-1's, then that is fine, if that is what it is going to take to defend the country. But if you could get by on 95 and give me the money that you would spend on the other 5, I can solve an awful lot of the educational problems in this country.

The same thing could be said for all of these cost effective programs that public witnesses such as you come in here and testify on. And the most amazing thing is that the money spent on the immunization program is the best money the Government spends. We get the greatest return on our investment in those programs.

They are always the ones that this administration seems to want to cut first.

Thank you very much for being with us this morning.

Ms. **Vankevich**. Thank you.

STATEMENT OF MARILYN PRICE SPIVACK, PRESIDENT, NATIONAL HEAD INJURY FOUNDATION

Senator **Bumpers**. Our next witness is Marilyn Price Spivack, president of the National Head Injury Foundation, Inc.

Welcome.

Ms. **Spivack**. Thank you, Senator.

Senator **Bumpers**. Please proceed.

Ms. **Spivack**. First of all, I want to thank you and your colleagues for the wonderful support you have given us over the past few years, and I just wanted to tell you, Senator, that some good things are beginning to happen in the State of Arkansas in head injury, and I am delighted about that.

Right now we are here today to ask for new dollars, new dollars for traumatic brain injury. We as a society have made a commitment to save people after they are traumatically injured. It is now time that we take the next step to make the most of those lives that we spend so much on saving.

Patients with head injury require a multitude of services over extended periods of time, often a lifetime, and we need the establishment of a well coordinated system of care from the onset of medical services in trauma to the delivery of support services in the community. Families of these patients also need specific attention, services, and economic relief from catastrophic financial burden.

We have asked for particular funds in RSA, for $3 million for the continuation of training and personnel because there aren't enough trained personnel to understand our population.

At the present time we need more significant funds going into supported employment programs because most employment programs of all kinds, particularly in supported areas, are for mental retardation. We need more funds in the independent living program. We are asking for $2 million in that area.

Under special projects we are requesting $5 million for the development of model community plans and programs to assist and treat persons with head injuries, and I call to the attention the work that was done by the mental health department, the NIMH, in developing a community based plan. That plan is outstanding for people with mental health problems, and that is the kind of plan that we are looking for.

We urge that special education have significant new funds. Our biggest problem is that special educators do not understand head injury, children with head injury, and they have no way of assessing children particularly with minor and moderate head injury.

We are asking that the National Institute of Mental Health be given significant appropriations so that they can begin and continue—actually, really begin research on cognitive and personality disorders caused by traumatic brain injury. These are small but significant resources which would provide a major step forward in helping persons who have really tried to hard to move forward.

We are confident that with greater attention to the planning of an integrated community system of services, the outcome for survivors will be worth the investment of Federal dollars. The cost of rehabilitation and support services is less expensive than the current drain of reducing or eliminating an individual and family's ability to work.

If I did not have a support system for my daughter, there is no way I would continue to be able to be a wage earner. But there are very few families out there with severely head injured patients that can maintain their own jobs, and that is another issue besides the loss of the future of the person that has been disabled.

We have here, if I may take a minute, a young man in the back of the room. His name is Robert Demikalis. He was working as an accountant for Peat Marwick at the time of his injury. Since his injury, if he walked right up here—and I'm going to ask Robert to stand up—Robert, will you stand up in the back of the room—you would never, never recognize the fact that Robert Demikalis is disabled. He is so disabled that he cannot get a job and has not been employed since his injury, and he was on his way to be an outstanding young accountant.

We are asking this committee to look to this population. You have made a difference in the lives of those with Alzheimer's, with AIDS and with mental illness. Head injury affects 700,000 people a year; 50,000 to 70,000 are left severely disabled, physically, mentally, and emotionally disabled.

We need your help. The cost of caring for a severely head injured person, much more severely than Robert, can cost $2 million to $4 million over their lifetime. We continue to ignore this.

PREPARED STATEMENT

I am asking for your help, for your mandates to prevent head injury and to improve the quality of the over half a million persons each year who sustain such injury. You are our hope for the future.

Thank you.

[The statement follows:]

STATEMENT OF MARILYN PRICE SPIVACK

> "The aggregate present value of William's future medical and rehabilitation expenses, including the hospital reserve fund and surigical treatment of the myositis, is from $2,918,199 to $3,209,378."
> ("private economic report," for William X, 1983)

Thus concluded the economic report on a single head injury victim. The report also said "William has received aggressive rehabilitation treatment for 27 months. Although he still has severe cognitive and physical impairments he has responded well to the therapy regime. His progress to date has been extraordinary. There are no indications that his recovery will not continue but the pace, extent and duration of future progress cannot be precisely determined. There is a consensus among attending physicans that William will never be independent or employable."

William was 19 years of age at the time of his auto accident. He has had coma stimulation and rehabilitation for four years at an average cost of $127,750 a year. In some cases the cost long-term rehabilitation is as much as one million dollars per case.

In 1980 families of head injury survivors came together to improve the quality of life for head injured survivors and their families. Out of this first meeting has come the National Head Injury Foundation, Inc. (NHIF). In eight short years, NHIF has grown to become an organization of 35 State Associations, 8 Affiliates, 350 support groups and over 20,000 members (survivors, families and concerned professionals) providing support, information, education and advocacy for individuals suffering brain damage after head injuries and making public awareness and education one of its critical goals.

On May 14, 1985 the NHIF entered into a cooperative agreement with Office of Special Education and Rehabilitative Services (OSERS). That Agreement has become a valuable working document that is already producing an increased awareness and interest in research, training and dissemination of information at the Federal and State levels. At this time, sixteen NHIF State Associations have signed similar agreements and the remaining 34 states are working closely with their Department of Rehabilitation.

It is estimated that each year 400,000-500,000 Americans are admitted to hospitals following traumatic head injuries which cause brain damage. The majority of victims are under age 35. Two-thirds are male. The primary cause of head injuries is motor vehicle accidents. Forty to fifty thousand persons (10%) are left annually with severe and complex disabilities which affect them physically, intellectually and emotionally.

These patients require a multitude of services over extended periods of time-often a lifetime-illustrating the need for the establishment of a well-coordinated system of care from the onset of trauma to the delivery of support systems in the community. Families of these patients also need specific attention, services and economic relief from the catastrophic financial burdens.

The majority of head trauma victims who sustain a so-called "mild" head injury are discharged from hospitals after brief evaluations, with satisfactory or good prognosis. However, recent studies have proven that victims of mild head injuries may experience cognitive impairments, memory loss, personality changes, extreme headaches and/or fatigue, as well as other impairments which interfere with and disrupt their lives.

Currently, only a small fraction of the head injured population receives appropriate care and services, that would provide the opportunity to return to an optimum level of function. The NHIF can only estimate that one in twenty may be fortunate to have the private funding to access the system of head injury care available. Oftentimes that system, too, may be fragmented and spread across the country causing further stress and burden to both patient and family. It is common that their caretakers and family members bear the enormous burden of emotional turmoil, economic loss, dysfunction of siblings, marital break-up and loss of jobs.

In the Department of Transportation HS 807 052 Final Report, June 1986,-"A Preliminary Study of Head and Neck Trauma of Motor Vehicle Crashes and Their Consequences", Vol. 1, the following statement was made-"Head injury outcome is important not only to the patient and his significant others, but also to society. It is estimated that injury costs $96 billion a year in direct and indirect costs. The events have far reaching financial, emotional, and societal ramifications for the patient and the society or system of which he/she is a part. Society should be informed of the everlasting affect of head injury."

Chairman Chiles your support to include report language in appropriations bills has been instrumental in addressing the numerous needs and issues affecting persons with head injury. Most importantly, report language in the House last year calling upon the Secretary of Health and Human Services to establish a Interagency Head Injury Task Force was one of the most critical steps that has yet to be taken to begin addressing the needs of persons with head trauma. The Foundation is excited about the prospects of this task force and is confident that further advances will be made as a result of its operation. The Foundation also applauds Dr. Murray Goldstein, with the National Institute on Neurological and Communicative Disorders and Stroke, for his outstanding leadership in research of head trauma and the Interagency Head Injury Task Force.

This past November, the National Institute on Disability and Rehabilitation Research (NIDRR) held a conference on traumatic brain injury research. The Foundation was very pleased with the conference and felt that it will be extremely valuable in advancing services for persons with head injury. In the very near future, a summary and report will be published which will serve as an excellent resource for further research and training of treatment of persons with head injuries.

While the Task Force and the NIDRR conference are a tremendous start there is still very much that needs to be accomplished. One of the aims of the Federation, as well as the charge of the Task Force, is to develop a coherent, adequately funded "system of care" for those who have experienced head injury and their families.

A second tragedy of head injury occurs in many thousands of cases when the final clinical note reads: "Discharged to home." What the note omits is: "Due to lack of funding." The NHIF supports the proposed funding as recommended by the Consortium for Citizens with Developmental Disabilities (CCDD) -- but we must look to you again for your aggressive action. For the past 6 years we have tried to work with Federal and state agencies to start meaningful programs in training, research as well as the development of model programs and clinical services. Other than the NIDRR and Rehabilitation Services Administration (RSA) nothing has occurred. With OSERS, we are now as far as we can go without draining funds from other disability areas -- that is not our intent or desire. Head injured survivors and their families should be as worthy of new appropriations as the tragic victims of AIDS, Alzheimers Disease and mental illness. You have helped us create an awareness, now it must be fueled by new resources.

In RSA we ask you to direct $3 million for the training of personnel to deal with the specific needs of the traumatic brain injured (TBI). At the present time we do not have adequate personnel to serve this population. We ask that $2 million be provided for the Independent Living program for TBI. For the most part, persons with head injuries are excluded from this valuable program. Under the Special Projects program we request $5 million for the development of a model community program to assist and treat persons with head injuries and their caregivers. We urge that $3 million be provided for early identification and training. In addition, we ask that under the National Institute on Mental Health (NIMH) $5 million be provided for research of personality disorders caused by TBI. These are small but significant resources which provide a major step forward for persons with head injuries.

We are confident that with greater attention to the planning of an integrated community system of services the outcome for survivors will be worth the investment of federal dollars. The cost of rehabilitation and support services is less expensive than the current drain of reducing or eliminating an individual's ability to work. Added to this problem is the caregivers contribution. Caring for a severely brain damaged person is not unlike caring for a victim of Alzheimers -- only in the fact that the average length of life after a severe head injury may be 30 to 50 years! We request support of NHIF recommendations for appropriations for the following programs that will impact upon the lives of those who sustain head injuries, and all others who are disabled by injury or disease:

A) Section 110 Rehabilitation State Grants: $1,550.1 million

State Vocational Rehabilitation Agencies are only able to serve approximately one out of every twenty eligible persons with disabilities. In 1987 and 88, persons with head injuries are now becoming identified and requesting services. This level of appropriation must be met to help meet the goals of the NHIF/OSERS agreement which promotes service delivery.

B) Supported Employment Services: $280.06 million

This new initiative be fully funded, as it is a needed program to give persons who are severely disabled by head injury the opportunity to achieve employment in integrated community settings.

C) Rehabilitation Training: $35 million

In all rehabilitation, training of personnel is the most important element in providing effective services to persons with disabilities. Nowhere is this more true than in the rehabilitation of persons with head injuries whose special programmatic needs are only beginning to be appreciated. Rehabilitation training grants are critical to ensure that there will be adequately skilled personnel available to provide rehabilitation services to persons with head injuries and other disabilities. We urge the Committee to fully fund this program and, if achieved, request that the Rehabilitation Services Administration set aside specific funds for training of personnel in head injury rehabilitation.

D) Special Demonstration Programs, Section 311, Rehabilitation Act: $28.3 million

The NHIF would suggest new monies be appropriated under this program, as the response to this program under 1986 RSA's requests for proposals was overwhelming. Fifty-four proposals were submitted and only 4 proposals could be funded.

E) Comprehensive State Services for Independent Living: $13.05 million

NHIF would encourage Congress to commit to the establishment and funding of an independent living service delivery system that would enable disabled persons to obtain their optimum level of function-thereby decreasing their dependence and increasing their productivity.

F) Centers for Independent Living: $27.3 million

The funding increase will provide for the continuation of the current programming level, and allow for the funding of additional Centers. New Part B grants give priority to geographic areas in State which are currently not served or underserved by independent living centers. The NHIF can document that there is a dearth of such needed programs for severely head injured young and older adults across the country.

G) National Institute on Disability and Rehabilitation Research: $55 million

The 7.6% increase over the 1988 level would enable the Institute to fund about the same number of new field initiated and innovative research grants as FY 84 & 85 and meet the level of 50 new grants established by the appropriation committee. In light of the impact of needs in research and training, systems of model programs and a national data system required for persons with TBI, the NHIF would request Congress to add new monies earmarked for this urgent initiative and priority area.

H) Education of Children with Handicaps, State and Local Grants: $2,148.66 million

The Foundations funding recommendation would fulfill the congressional mandate of expanding the age range and scope of services without placing unreasonable demands on state and local levels. The NHIF has requested OSEP and State Special Education agencies to indentify head injured children and adolescents and to survey their needs.

I) Special Education Personnel Development: $79 million

We request this level funding to provide training for special education and related services professionals who have requested specific training to meet the needs of traumatically head injured children and youth.

J) National Institute of Neurological and Communicative Disorders and Stroke: $704.5 million

Stable growth for research in the neurological sciences is critical if medical researchers are to keep pace with the opportunities which technology is making possible. The short-term savings which would be derived from a 15 percent drop in the number of new grant awards must be weighed against long-term human and economic costs. The FY 1989 NHIF recommendation would enable the Institute to maintain stable growth of its research grant portfolio.

K) National Institute of Mental Health and Research Training: $400 million (excluding AIDS research funding)

Although the NHIF supports appropriation for AID research funding, we can no longer ignore the mental health needs of head injured people and their families. Behavioral and psychological deficits are proven to be the major factor in the long-term disabilities of traumatically head injured persons. To continue to ignore this tremendous need will result in lifetime disabilities which cost this country billions of dollars and incalculable human suffering.

L) Developmental Disabilities, State Grant: $69.9 million

The NHIF recommendation is a 20% increase over the FY 1988 appropriation, an amount necessary to bring the program to a funding level commensurate with its mandated responsibilities. The incidence of injuries amongst children is estimated at one million annually-average incidence ranges from 190/220 per 100,000.

Lastly, we support the necessary funding for the Center of Injury Control to operate at its maximum level.

As the 100th Congress comes to a conclusion, we are asking your assistance in meeting the needs of head injury survivors for increased programs and services. The wisdom and far-sighted decisions of past Congresses have made significant changes in the lives of those who are disabled and chronically ill. Today, we need your legislative mandates to improve the quality of life for the one-half million persons who sustain head injuries each year. The 100th Congress is our hope for the future of our loved ones.

STATISTICS OF TRAUMATIC HEAD INJURY

1) Trauma - major cause of death and disability under age 35.
2a) Two-thirds of all victims between ages of 15-25.
b) Male to female ratio of injury - 2:1
3) 200/100,000 head injuries a year; approximately 50,000 left with severe disabilities.
4) Trauma - greatest threat to life in childhood ages 0-14; head trauma accounts for about 16% of pediatric hospital admissions.
5) An estimated 1 million children sustain head injuries annually, including those treated in emergency rooms.
6) 25-40% of abused children will suffer a head injury.
7) 50% of battered children surviving a cerebral injury suffer permanent neurological, intellectual and psychological impairment.
8) Average annual incidence rate of pediatric head injury ranges from 190-220 per 100,000 including hospital admissions and fatalities which occur before child reaches hospital.

Senator BUMPERS. Thank you very much, Ms. Spivack.

You heard my comments to the preceding witness about how I wish we could grant every request you make for funding. And if I were king of this country——

Ms. SPIVACK. I think you ought to be also. I think this whole committee should share that throne.

Senator BUMPERS [continuing]. I would rearrange the priorities so that we could meet your request. Unhappily, we are under such severe budget constraints that——

Ms. SPIVACK. I understand that, Senator, and I am making these requests for a very specific reason. We need to be on record for asking. We need to be on record for understanding that this population continues to be the unserved and underserved disabled population in this country, and we need to bring attention to that.

Senator BUMPERS. You heard Ms. Brady testify just before you did?

Ms. SPIVACK. Yes; I did.

Senator BUMPERS. We are talking about the same independent living program, are we not?

Ms. SPIVACK. That is right, right. The problem with the independent living programs as it exists today, they are set up so in most areas that they do not well serve our population, No. 1, because of training of personnel in the programs in those independent living programs. The independent living programs and supported work are keys to our future. What we are asking for is the independent living programs be adjusted and adapted to serve our population, because our population is so unique in terms of their physical and cognitive disability that they do not always fit in merged with the existing independent living programs. Sometimes they do but oftentimes they do not, and that is what we are looking for new appropriations or some appropriations out of the existing appropriations to look at that problem.

Senator BUMPERS. Thank you very much for being with us this morning, Ms. Spivack.

Ms. SPIVACK. Thank you.

Senator BUMPERS. Our next witness is Joni Fritz, executive director, National Association of Private Residential Resources.

STATEMENT OF JONI FRITZ, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF PRIVATE RESIDENTIAL RESOURCES

Ms. FRITZ. Good morning, Senator Bumpers.

Thank you for giving us an opportunity to testify before you today.

I represent the National Association of Private Residential Resources. Our association currently represents more than 650 agencies in 49 States that together provide residential services to more than 40,000 people with mental retardation and other developmental disabilities.

Our members offer a full range of residential services in a variety of settings designed to enhance the development and self-dependence of those served. Funding for residential services varies from State to State and agency to agency. Our members utilize a variety of funding streams.

Our written testimony focuses on four programs under the purview of this subcommittee that are of particular concern because they provide significant support for residential services, including the independent living program.

The statement submitted for the record describes our recommendations in greater detail, but I will focus on just two other programs, Medicaid and Social Security today.

In brief, we first ask this subcommittee to oppose the administration's plan to reduce Medicaid expenditures by arbitrarily redefining education services which cannot be reimbursed by Medicaid to include training and activities of daily living. Our printed statement discusses the inequity of this latest plan to reduce Federal support for services that in the long run will reduce dependence upon Government programs because they teach people to be more self-sufficient.

Second, our association asks this subcommittee to reject cuts in Social Security Administration staff proposed in the President's budget. My personal family experience demonstrates the hardship such proposal would create for people who are disabled. My husband has severe traumatic brain injury. He currently receives veterans' benefits and Social Security disability insurance.

His speech is very limited as a result of his injury, and his level of understanding is also somewhat impaired. Nick lives at home, and I am his legal guardian. He is able to read a little, and when he receives notices that his disability benefits are about to be reviewed and that this could result in a termination of his benefits, it creates a considerable amount of anxiety. He remains anxious from the time he receives the notice that an appointment must be made to review his case, through the review process until the letter affirming his continued disability arrives in the mail.

He is not as aware as I am that the level of his disability is so severe that he will probably indeed be continued to be found disabled enough to receive benefits.

PREPARED STATEMENT

People who apply for and receive Social Security benefits represent the most needy people. Many like my husband and the people served by our association members have severe mental disabilities. They are individuals who have a difficult time dealing with bureaucracy even at current levels, and reductions in personnel are unacceptable and should be rejected.

I see my time is up. Thank you for giving me your attention.

[The statement follows:]

STATEMENT OF JONI FRITZ

The National Association of Private Residential Resources (formerly the National Association of Private Residential Facilities for the Mentally Retarded) currently represents more than 650 agencies in 49 states and the District of Columbia that together provide residential services to more than 40,000 people with mental retardation and other developmental disabilities. Our members offer a full range of residential services in a variety of settings designed to enhance the development and self-dependence of those served. Most NAPRR members serve people at more than one site. Funding for residential services varies from state to state and agency to agency.

For purposes of this testimony, NAPRR has chosen to focus on four programs under the purview of this Subcommittee that are of particular concern because they provide significant support for residential services.

MEDICAID

It is estimated that about 800,000 people with developmental disabilities receive Medicaid benefits. Thousands of these with severe mental and physical disabilities receive Medicaid assistance for residential services in intermediate care facilities for the mentally retarded (ICFs/MR), or through the Home and Community Based Services (HCBS) Waiver program.

Although the Administration's FY 1989 budget contains no proposed statutory restrictions on Medicaid payments, a number of regulatory initiatives are planned which would trim an estimated $413 million from expenditures that would otherwise be incurred. Approximately $30 million of the proposed decrease in spending would be the result of a planned reduction in state Medicaid payments for "educational services" provided in ICFs/MR. To implement this recommendation, the Department of Health and Human Services would "conduct audits, clearly define 'special education' and revise current regulations to reflect the new definition [of education] in order to ensure that only medical services in an ICF/MR are covered by Medicaid."

The implied contention is that states are claiming reimbursement for non-medical special education costs. This position is reflective of a long-standing debate between HHS and the states regarding the definition of "education services" in the ICF/MR context. Services that would usually be considered training in activities of daily living are sometimes identified by HHS auditors as "educational," and thus not reimbursable under the Medicaid program. Exactly how they should be defined is certainly debatable, arguments have been presented on both sides of the issue. The fact remains that these are not traditional academic areas of instruction and they represent essential components of an individual's training. They are directly tied to a program of active treatment and are essential if the people living in ICFs/MR are to develop skills necessary to move from an environment where they receive 24-hour supervision to less costly semi-independent or independent living arrangements. Eliminating funding for training in activities of daily living will significantly limit the ability of ICFs/MR to help people become less dependent. This would be a counter-productive move. The most cost-effective services are the habilitation services designed to increase the self-dependence of those served so that they no longer depend upon a full array of staff and support services.

NAPRR respectfully asks Congress to oppose the Administration's plan to reduce Medicaid expenditures by arbitrarily redefining ineligible "education services" to include training in independent living provided to help people in ICFs/MR become more self-sufficient.

SUPPLEMENTAL SECURITY INCOME

The Administration's FY 1989 budget proposes an estimated reduction of about $29 million in federal SSI benefits, when compared to FY 1988. A portion of the decrease is due to the fact that just 12 payments will be made in FY 1989, while 13 will be made this year. This will be partially offset by a cost of living adjustment (estimated at 4.2%) and a projected increase in beneficiaries of 121,000 people. The Administration's budget also proposes a decrease in the number of employee positions for the Social Security Administration, however. The equivalent of about 4,300 full time positions (constituting about 94% of the cuts in the HHS budget request) are slated to come from the elimination of positions within the Social Security Administration. This would represent a reduction of about 6.2% from the FY 1988 staffing level, and an overall reduction of approximately 8.1% from FY 1987 levels.

Cuts such as these proposed by the Administration would delay review and approval of benefits for SSI applicants and recipients. Adequate staffing is essential to ensure that people who apply for benefits, and those now on the rolls who are subjected to periodic disability reviews, have their eligibility for benefits determined in a timely and equitable manner. People who apply for SSI benefits represent the most needy citizens. They are not only elderly, blind or disabled, but also poor. Many have mental disabilities. They are individuals who have a difficult time dealing with bureaucracy, even at current staffing levels. Transportation is also often a problem. Reductions in personnel, that may force these individuals to travel further to district offices, or deny them the personal attention they need to properly complete application forms and other paperwork, are unacceptable and should be rejected by Congress.

NAPRR recommends that Congress reject cuts in Social Security Administration staff proposed in the President's budget.

SOCIAL SERVICES BLOCK GRANT

Conversion of the Title XX Social Services program to a block grant, with the cut in appropriations, was supposed to be accompanied by a return of revenue sources to state and local governments. That part of the plan was never implemented. As a result, states have been left with reduced Federal funding and no new revenue sources to support community programs. If the FY 1981 funding level were adjusted for inflation, more than $4 billion would be required in FY 1989 just to maintain services provided in 1981.

The Administration has recommended that $2.7 billion be appropriated for the Social Services Block Grant in FY 1989. This represents a three year freeze in funding. It is the amount appropriated in both FY 1987 and 1988. Cuts at the beginning of the 80s and the two-year freeze have seriously eroded support for community based services for people with disabilities. In many communities this program, coupled with SSI, is the only resource for services other than more costly institutionalization. To further cut this program may well put additional demands on other more costly Federal programs — most specifically Medicaid.

NAPRR recommends that $3 billion be appropriated for the Title XX Social Services Block Grant Program in FY 1989.

COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING

The National Council on the Handicapped estimates that almost 400,000 people with disabilities could benefit from Independent Living Services under Title VII of the Rehabilitation Act. With more adequate funding, the Part A Comprehensive Independent Living Services Program, in conjunction with the Part B Centers for Independent Living program and the Part C Older Blind Individuals Independent

Living Services program, could provide vital services to an ever-increasing number of individuals with severe disabilities.

The Administration is seeking a 2% increase in funding for the Part A Independent Living Services program and proposes a freeze in funding for the Centers in FY 1989. With the effect of inflation, that would reduce the current level of services under both parts. It would also prohibit expansion of the Part B program to reach those geographic areas not yet served by a Center, a priority stated in statutory amendments to the program.

NAPRR recommends that $13.05 million be appropriated for the Title VII Part A Independent Living Services program, and $27.3 million for the Part B Independent Living Centers program for FY 1989. These figures represent modest increases but would bring both of these programs to the full authorization level.

DEPARTMENT OF LABOR INTERPRETATIONS AFFECTING RESIDENTIAL STAFF

Some members of this Subcommittee are aware of the problems recently experienced as a result of U.S. Department of Labor interpretations of hours worked by people who are employed in community residences for people with disabilities.

NAPRR would like to take this opportunity to thank the Members of Congress who have supported efforts to obtain clarification of interpretations of the Fair Labor Standards Act to permit individualized staffing patterns perferred by employees that at the same time prevent exploitation. Most residential programs that serve people with disabilities are supported almost entirely through government funds — Federal, State and local. It is difficult for the private sector to obtain adequate funding to pay wages that are commensurate with the work done, or even to achieve wage parity with the public sector. We are also acutely aware that if new interpretations were applied retroactively, the future of many excellent community residential programs would be threatened, and that the demand on federal funding programs could increase substantially if people have to be paid for time they are not actually working.

Although this issue has not yet been completely resolved, interest expressed by a number of Members of Congress has brought the matter closer to resolution. We are most appreciative of the help given.

Senator **Bumpers**. Thank you very much.

Let me just ask you this question.

What is the current block grant for title XX?

Ms. **Fritz**. The Social Security block grant program once provided considerable money to the States to be matched and were usually used for those services that support a residential program, but in the early 1980's it was converted to a block grant. The funding was cut 25 percent. And with the cut, there was a promise that tax resources would be returned to the States, but that has not occurred, and there is considerably less money available there than there was 8 years ago.

Our association also supports the appropriation levels in the document I believe you and other Members of Congress have received that was developed by the Consortium for Citizens with Developmental Disabilities, and there is more than a page discussing the title XX social services program.

Senator **Bumpers**. What State are you from?

Ms. **Fritz**. I currently live in Virginia and——

Senator **Bumpers**. Is your office here in town, in Washington?

Ms. **Fritz**. In Virginia, right across the river.

Senator **Bumpers**. How do you feel about the block grant program? Do you think it has worked OK?

Ms. **Fritz**. Well, currently the funding has been reduced so significantly that we find that people with varying needs are all competing for the program so that we actually have had to look for a lot of other resources, and that is one reason why the independent living program has become a greater interest to us. People who are aging, people with a lot of different kinds of needs also access the title XX program.

Senator **Bumpers**. Incidentally, you hit on one of the favorite tactics of this administration, and that is because Congress refuses to cut funds for some of these very——

Ms. **Fritz**. Thank goodness.

Senator **Bumpers** [continuing]. Worthwhile programs, they change the regulations to try to accomplish the same thing.

Ms. **Fritz**. Yes.

Senator **Bumpers**. The redefinition of education, of course, which is not reimbursible, is typical of the kinds of things they do.

Ms. **Fritz**. And it is so counterproductive because skills in daily living I think are arguably not really educational services in the traditional academic sense, and when they enhance someone's self-dependence, it enables people like my husband to live at home and to reduce their dependence upon these support programs.

Senator **Bumpers**. Yes.

Well, thank you very much for being with us this morning.

Ms. **Fritz**. Thank you, Senator Bumpers.

STATEMENT OF THOMAS L. BIRCH, LEGISLATIVE COUNSEL, NATIONAL CHILD ABUSE COALITION

Senator **Bumpers**. Our next witness is Thomas L. Birch, legislative counsel, National Child Abuse Coalition.

Mr. Birch, welcome to the committee, and please proceed with your testimony.

Mr. BIRCH. Good morning, Senator. Thank you for the opportunity to present testimony this morning to you on the subject of Federal funding for child abuse prevention and treatment programs through the National Center on Child Abuse and Neglect in HHS.

I am here this morning to urge an increase in these programs for several reasons. As I am sure you are aware, reports of abused and neglected children increase every year. A survey conducted this year by the National Committee for Prevention of Child Abuse shows that 2¼ million reports of child abuse and neglect were filed in 1987. The consequences of these cases are costly. Each case of child abuse generally costs $2,000 or more just for an investigation and short-term placement. When a child has to be hospitalized or put into foster care or a parent is incarcerated, costs rise significantly.

And there are other ways in which we pay for the abuse of children. Clinical records show that a history of abuse or neglect in from one-quarter to one-half of children handicapped by mental retardation and cerebral palsy have been abused, and the same kind of figures show for adults and children in treatment for severe psychological disorders.

In the reauthorization of the Child Abuse Prevention and Treatment Act this year, Congress has mandated studies and research to look at that link between disability and the abuse of children.

Other consequences include the overwhelming numbers of juvenile delinquents, adolescent runaways, criminal sexual offenders and prostitutes who report childhood histories of battering and exploitation.

In addition, child abuse fatalities remain high, 1,181 children died as a result of maltreatment. That is three child-abuse related deaths every day. And those numbers are up by 25 percent between 1985 and 1987.

Child protective services find themselves hard-pressed to address the tremendous growth in reported abuse and neglect. Last year, over one-half the States showed that funding for their programs had either stayed the same or had decreased. These restricted budgets mean fewer case workers and fewer services available to families in trouble.

State and local child protective services, faced with increasing demands for services, are having to prioritize their cases. A large number of neglect reports are going for lowest priority of investigation. In other cases, the child's age is a determining factor. A child over the age of 12, for example, reported as abused, may get low priority for help.

Funding for abuse and prevention activities across the country has not kept pace with the demand for services. In the face of increased child abuse reports over the last 3 years, the funding for the National Center on Child Abuse and Neglect has dropped below the 1985 level when that funding was last increased through the leadership of this subcommittee.

The reauthorization that Congress enacted just a month ago increases the authorized funding level, and we see that as a signal for a modest increase in the budget.

The prevention challenge grants, the other program that comes for child abuse funding through this subcommittee, also is a program that has not met the required funding level. Last year appropriations for these grants at $4.8 million were not enough to match the 4-to-1 required by the statute. We are requesting that the Federal challenge grants be brought to $7 million in order to meet that statutory match.

I see that my time has expired. You have our written testimony with the other specifics in it on our request.

[The statement follows:]

STATEMENT OF THOMAS L. BIRCH

Mr. Chairman, members of the Subcommittee, my name is Thomas Birch. I am the legislative counsel for the National Child Abuse Coalition, an advocacy group composed of national organizations concerned about the future of services for the prevention and treatment of child abuse and neglect.

I want to thank the Subcommittee for the opportunity to present testimony this morning on the subject of federal funding to child abuse prevention and treatment programs through the National Center on Child Abuse and Neglect.

Numbers of Children Abused

Child abuse is a national problem of large proportions. Reports of abused and neglected children are annually on the increase. A survey conducted this year by the National Committee for Prevention of Child Abuse shows that 2.25 million reports of child abuse and neglect were filed in 1987. Since 1981, the reports of child maltreatment increased by 84 percent.

The consequences of child abuse are costly. Each case of child abuse generally costs $2,000 or more just for an investigation and short-term placement. When a child must be hospitalized or put in foster care or a parent incarcerated, the costs rise significantly.

Clinical records indicate a history of abuse or neglect in from one-quarter to one-half of children handicapped by mental retardation and cerebral palsy, and the same for adults and children in treatment for severe psychological disorders. Overwhelming numbers of juvenile delinquents, adolescent runaways, violent criminals, sexual offenders and prostitutes report childhood histories of battering and exploitation.

In addition, physical abuse or severe neglect end each year in the death of children. Child abuse fatalities remained high last year — 1,181 children died as a result of maltreatment; three child abuse related deaths every day — and those numbers are up by 25 percent between 1985 and 1987.

Services for Abused Children

Child protective services are hard pressed to address the tremendous growth in reported child abuse and neglect. Last year, over half the states showed that funding had either stayed the same or had decreased. Restricted budgets mean fewer caseworkers and fewer services available to families.

While all state agencies are required by state law to investigate abuse and neglect reports within one or two days, about one-third of the states have indicated that they are unable to investigate within the required time.

State and local child protection agencies, faced with increasing demands for their services, have been forced to prioritize cases based on the severity of the report. A large number of neglect reports are given lowest priority for investigation. In other cases, the child's age is often a factor in determining priority.

These efforts to curtail the number of reports an agency must investigate, approaches which were only hinted at five years ago but have since become commonplace, are an unavoidable consequence as long as budget increases are limited or non-existent.

Inadequate NCCAN Funding

Funding for child abuse prevention and treatment activities across the country has not kept pace with the demand for services. The 1987 report of the Select Committee on Children, Youth and Families found that total resources — federal, state, and local — to serve abused and neglected children increased, in real terms, by less than 2 percent between 1981 and 1985. In the face of increased child abuse reports, the federal budget for NCCAN has grown by only 8 percent since 1981, and over the last three years, the NCCAN appropriation has dropped below the 1985 level.

Through the National Center on Child Abuse and Neglect, the federal government provides an important measure of leadership in demonstrating improved ways of preventing and treating child abuse and in addressing problems of national concern. National leadership is important to help states and communities protect children and build strong families.

Increased authorizations for NCCAN signal agreement about the need for higher appropriations. Money for NCCAN has lagged behind the authorized level for several years. This year, Congress enacted legislation to raise the authorization for NCCAN to $48 million from $43.1 million, indicating a desire to provide an increase in the budget for NCCAN.

The new federal child abuse act also mandates several new studies which, depending on their scope, could demand $2-3 million in new spending. In 1987, NCCAN was only able to fund 1 out of every 10 grant applications it received. Without additional funding, NCCAN's current budget level may only be adequate to support the mandated research and continuation grants, leaving no funds for start-up support of new initiatives from the field.

For these reasons, the National Child Abuse Coalition urges an increase in appropriations to the National Center on Child Abuse and Neglect to $40 million in fiscal 1989.

Prevention Challenge Grants

The child abuse prevention challenge grants provide incentives to states to establish and improve their support for prevention activities. When this authority was first enacted four years ago, less than half the states had set up special funds for child abuse prevention. Now, all but four states have developed resources. The federal matching grants have been highly instrumental in convincing state legislators to provide funding for prevention.

Prevention challenge grants must match state prevention funds as provided by the Child Abuse Prevention Challenge Grants Act. Last year, appropriations for challenge grants at $4.8 million were not enought to match by 4 to 1, as the law maintains, the $28 million in state funding for child abuse prevention.

The federal prevention challange grants should be brought to $7 million in order to meet the statutory match.

National Priority on Child Abuse

The National Center on Child Abuse and Neglect can target a limited amount of federal money on child abuse that means extra spending at the state and local levels. This program offers seed money needed to develop services than can stand on their own feet.

Funds to state agencies have been successful in interesting other public and private agencies to sponsor programs for treating and preventing child abuse. State funds have been appropriated to carry foward support for programs that were developed with NCCAN grants.

Improved support for NCCAN will continue to emphasize child abuse as a national priority receiving the attention it deserves.

Senator BUMPERS. Mr. Birch, what is the most effective prevention program that you have?

Mr. BIRCH. We find that working with young parents, particularly teenaged parents and people who are having difficulty in knowing what to do in raising a child. There are parent aid programs——

Senator BUMPERS. How do you find them? I mean, how do they get into the system?

Mr. BIRCH. Usually it happens if the young mother is coming for prenatal care, then we find those women coming to hospitals and their pediatricians, to local clinics. If not, when the woman comes to the hospital for delivery, there are volunteers who have been trained as parent aides that develop a relationship with the parents, the mother, if she is single, during the delivery process, and then continues over a period of months or even a year or more, making home visits, so that that young woman, often a child raising a child herself, knows what to expect and what kind of demands are reasonable to make on a child.

Senator BUMPERS. Does the economic status of parents have anything to do with the probability of child abuse? Is it more a poverty issue, or do you find upscale yuppies also abusing children?

Mr. BIRCH. We find that child abuse cuts across all economic levels, but because unemployment and low-income levels create additional stresses on families, there is more of a risk in those populations.

Senator BUMPERS. Is child abuse on the increase?

Mr. BIRCH. Yes, it is.

Senator BUMPERS. Do you deal also with foster care children?

Mr. BIRCH. Well, many of the children who are in foster care were abused as children, which is why they have been removed from their families for their protection and placed in foster care.

Senator BUMPERS. How prevalent do you find child abuse in foster care homes? I understand that abused children are sometimes removed from a family where they have been abused and put into a foster home. But I also keep reading stories about child abuse in foster care homes.

Mr. BIRCH. It occurs. It is a problem that Child Protective Services is constantly wrestling with in trying to find foster parents who are themselves prepared to be good parents for children who have already been hurt at home. Foster care training for these parents is another important area that needs attention.

Senator BUMPERS. Is there anything to the old saw that if you are an abused child, you are likely to become an abusive parent?

Mr. BIRCH. We find that there is a cycle of violence that goes from generation to generation. Obviously, not all children who were abused go on to abuse their children when they become adults, but there is a link. Children learn that this is a way that you solve your interpersonal problems in a family, by lashing out and striking someone who is giving you trouble.

Senator BUMPERS. So parents are likely to raise their children the way they were raised.

Mr. BIRCH. Exactly, exactly. We all learn by example, and that example of violence in the home then goes on into the next generation.

Senator BUMPERS. You mentioned, I believe, in your testimony something about response time to allegations of child abuse, and that only 1 in 10 cases are being investigated in the time that they ought to be investigated because police, for example, say they do not have the resources and so on.

Did I get that right?

Mr. BIRCH. Well, the 1 in 10 I mentioned had to do with the percentage of applications that the national center and HHS has actually funded because of resources in their budget, but there is a tremendous burden on agencies to respond to calls for investigation.

Most agencies have, are mandated by State law to respond within 24 or 48 hours to reports but as I said, if those reports sound less severe, because there are so many coming in and not enough case workers to handle them, they get pushed aside.

Senator BUMPERS. Is there any difference between preschoolers and, say, elementary children in terms of frequency of abuse?

Mr. BIRCH. Generally, the more severe cases of abuse we see in younger children.

Senator BUMPERS. Preschoolers.

Mr. BIRCH. That is right.

Senator BUMPERS. Are teachers one of the most common complainants? Do they see children in their classrooms that are abused and report it? Is that a common thing?

Mr. BIRCH. Yes; actually, teachers are mandated in most States to report suspected cases of abuse, and they are high in terms of the percentage of that population that does report.

Unfortunately, other populations like physicians, which would see children who are injured, are not as likely to report. It is an area of training where we need more awareness in graduate schools, training for lawyers, social workers, teachers, nurses, physicians, when they go out and start working, they are going to be confronted with abused children. But it is not always part of their curriculum, so they do not recognize it and don't know how to respond to it when they see it.

Senator BUMPERS. Do you deal with both physical abuse and sexual abuse?

Mr. BIRCH. Yes; that's right.

Senator BUMPERS. When I practiced law in a small town in Arkansas, it was not uncommon for a woman to come in and tell me that her husband was sexually abusing a child, and that charge was so alien to me that I had difficulty believing it, frankly.

Now, in a more open society with television doing documentaries on this topic and so on, I realize now that when I think about how much of that I heard about in a little town of 1,500 people, I think about how pervasive that must be nationwide.

There was one other question I wanted to ask you about. Yes; can you tell me approximately how many child abuse cases were filed and how many resulted in the removal of children from a home where abuse has occurred?

Mr. BIRCH Unfortunately, we do not have statistics on removal, and this is another area in which the reauthorized Child Abuse Prevention and Treatment Act has asked for a study so that we can look at the number of cases that have been reported annually, the number that have gone to adjudication, and then what actually has been the result of that, whether the child was removed from the home or not.

This is information that we have not been able to collect before.

Senator BUMPERS. Do you find any differentiation in educational levels of parents who abuse children?

Mr. BIRCH. I cannot say that we do because, again, it happens across the board, and all characteristics, whether you are looking at education or income or ethnicity or geographical location, rural areas as well as inner city areas, that educational background is not one that shows up as a significant indicator.

Senator BUMPERS. Thank you very much for being with us this morning, Mr. Birch.

Mr. BIRCH. Thank you, Senator.

STATEMENT OF WILLIAM H. HOLLINSHEAD III, M.D., PRESIDENT, ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS

Senator BUMPERS. Our next witness is William H. Hollinshead III, M.D., president, Association of Maternal and Child Health Programs.

Dr. Hollinshead, welcome to the committee, and we are anxious to hear from you. And you are talking about one of my favorite programs.

Dr. HOLLINSHEAD. Thank you, Senator Bumpers.

We welcome this opportunity and recognize this year and in previous years both the committee's and your personal commitment to maternal and child health broadly defined, as well as the title V program.

I will move along quickly in view of the hour, and rely on the written testimony to include the details.

As noted, I am president of the Association of Maternal and Child Health Programs which represents the State and territorial programs funded under title V, which for over the last 50 years have been working to ensure that every American child is born well to a family and community that actively support and promote her and his optimal health and development.

We welcome this chance to share the knowledge and experience of the title V block grant programs for women, children, and families, and to ask your fiscal commitment to these programs and these policies.

Title V programs are unique among Federal programs in having a mandated responsibility to assess and develop strategies and programs to prevent death, disease and disability among this population, and for ensuring the availability of high quality health related services for mothers and kids.

These programs are particularly targeted to low-income mothers and children, and to children with special health care needs arising from chronic medical or developmental conditions.

Title V programs are also mandated to coordinate with other health, education, welfare and nutrition, and disability programs affecting children.

There is consensus that State MCH programs must take the lead in coming years within States to identify the large and growing number of needs and problems, bring together policymakers, public and private service providers, advocates and families to define the remedies and ensure that we implement initiatives including care and coverage expansions, monitor and evaluate their impact.

States' title V programs are now carrying out these roles, although resources and the mandate have not allowed us to address all MCH needs in all States.

In addition to planning, coordination, evaluation, and other leadership responsibilities, title V is the only federally funded program devoted entirely to this population and provides critical direct clinical services where needs have otherwise been left unmet. Recognizing the value of the program, the President's own budget recommends full funding for the coming year, $561 million, and additionally, I understand the Congress has recommended that this program be exempted from the recommended 1 percent across the board cut to be applied against discretionary programs.

We certainly strongly endorse the full appropriation to improve pregnancy outcomes, protect children's health and development. Since pregnancy takes many months and development takes many years, we also endorse this protection from unpredictable cuts and instabilities.

Finally, I would like to mention two vital and acute maternal and child health issues also now before you beyond title V appropriations themselves. The first, as you know, I am sure, AIDS has now reached infants and children. Last year's first appropriation for title V AIDS projects, $5 million, has helped to address the anguishing care and developmental issues of children affected by the human immunodeficiency virus. That has been very valuable, $10 million has been proposed for fiscal year 1989, which we strongly endorse.

Finally, in addition to the growing problem of AIDS, we have a crisis in the most basic and traditional of our public health programs, immunization. Proposed elimination of the immunization administrative support funds lead to rapid loss of State capacity to reach out and protect the most vulnerable children with vaccines, children that are hardest to reach. Some $40 million in funds is needed to be sure that the vaccine will reach the child we all hope to protect.

Thank you, and I will submit the rest for the written record.

[The statement follows:]

STATEMENT OF WILLIAM H. HOLLINSHEAD III

I am Dr. William Hollinshead, President of the Association of Maternal and Child Health Programs. Our Association represents state and territorial Title V programs which for over fifty (50) years have been working to ensure that every American child is born well into a family and community that actively supports and promotes her and his optimal health and development. We will share the knowledge and experience of the Title V Block Grant programs for women, children and families, and ask for your fiscal commitment to those programs and policies.

Title V Maternal and Child Health programs are unique among federal programs in having a mandated responsibility for assessing and developing strategies and programs to prevent death, disease and disability among children, and for ensuring the availability of high quality health related services. These programs are particularly designed for low income mothers and children, and for children with special health care needs arising from chronic medical or handicapping conditions. Title V programs are also mandated to coordinate with related health, education, welfare, nutrition and disability programs.

Leadership and advocacy for addressing the needs of mothers, children and families is not mandated by Title V, but has a history and tradition dating back to the Children's Bureau of the early part of this century. There is consensus among state MCH programs that we must take the lead within states to identify the needs and problems, bring together the policy makers, public and private service providers, advocates and families to define the remedies, to ensure the implementation of initiatives, and to monitor and evaluate their impact. And states are carrying out these rules.

Title V agencies have the responsibility to ensure that health promotion, disease prevention, primary care and specialty and family support services of high quality are available, accessible, affordable, comprehensive, and coordinated. Only in this way can America meet the identified needs of women, children and families, particularly those with low incomes and children with special health care needs.

The means by which each State ensures that systems of care are available and accessible to mothers, children and families may vary due to diverse state agency structures, state revenues, MCH allocations, service delivery systems and population characteristics. However, in each State, the role of MCH Title V programs is critical. Each State must ensure that effective and comprehensive systems of care are in place. These include:

- Providing information, education, outreach, training and technical assistance to families, professionals, providers and communities on how to effectively prevent or treat health problems, support the optimal functioning of children with special health care needs, and make effective use of existing services.
- Developing, ensuring implementation of and monitoring standards of care for public and private providers and payors.
- Developing, organizing, and managing systems of health care financed by a variety of payors, including Medicaid and private insurance.
- Coordinating the planning, delivery, and financing of health and related services for mothers, children, and families at the state, regional and local levels.
- Providing direct health care services through state managed programs, local health departments, contracts with community providers or payment for services provided by other public and private providers where services are unavailable or inadequately reimbursed through other public and private providers and payors.

- Promoting and often directly providing or subsidizing case management or care coordination services for families to assist them in obtaining and effectively utilizing available health, welfare, social services, educational programs, specialty medical and family and community support services.

- Developing and testing program models that are responsive to new and emerging information on health problems and effective interventions.

- Assessing the adequacy of public and private health care systems in providing available, accessible, affordable, high quality comprehensive care.

The Title V Block Grant programs are an integral part of the system of federal support for promoting the health of mothers and children. It is the only federally-funded program devoted exclusively to maternal and child health and it provides services where needs would otherwise be left unfilled.

In addition to the general Block Grant Programs, additional funds are allocated for projects for the screening of newborns for sickle cell anemia, for the development of child health demonstration projects and for the support of research and training, hemophilia projects and for special projects of regional and national significance (SPRANS).

In recognizing the value of this program, President Reagan's budget recommends full funding of $561 million. Additionally, as Members of Congress, you have recommended that this program be exempt from the recommended 1% across-the-board Gramm-Rudman cut to be applied against discretionary domestic programs.

In making your Appropriations recommendations for the 1989 fiscal year, the Association hopes that you will consider our recommendation of $561 million for the Title V Block Grant programs. This funding is vital. It is needed to provide public health officials with the capacity to insure that reasonable maternal and child health care services are available to those in need.

We thank you for this opportunity to present our recommendation and for your continued support.

Senator **Bumpers**. Thank you very much, Dr. Hollinshead.

There would not be any point in asking questions. We are just preaching to each other, and we are both saved.

I will say that your suggestion about the 1 percent across-the-board cut is premature, and hopefully we are not going to have to get to that. Fortunately, if we do make an across-the-board cut, MCH will be spared.

Apparently we have just about converted the President on MCH. You know, when the President was first elected, this was one of the programs he tried to cut dramatically. Senator Bentsen from Texas and I have always taken the lead in trying to get these funds restored, and have in fact been able to make sure that this program was not ravaged as some were.

But this subcommittee is the subcommittee that was responsible, really, for full funding for this program last year, even though we lost some of it in the House.

I guess the President is tired of losing, so he has recommended $561 million this year. And I cannot imagine anybody in Congress trying to cut that.

So I would say that we are going to have that much money for you.

Dr. **Hollinshead**. We are here to try to express on behalf of those mothers and children our gratitude for that protection.

Senator **Bumpers**. This has been a great program in my State. It is another program with a tremendous cost-benefit ratio.

Dr. **Hollinshead**. Speaking of Arkansas, I as you know come from a New England State, but I would point out that the interaction between the Medicaid extensions that have also been authorized and appropriated in the last couple of years, and the maternal and child health block grant has been one of the most positive developments in the last couple of years, and I think Dr. Bryant and some of the other people who have led the way on that collaboration between title XIX and title V in Arkansas have achieved national visibility and deserve real credit.

Senator **Bumpers**. Well, I notice Gil Buchanan is on your executive council. I assume you know Dr. Buchanan.

Dr. **Hollinshead**. Indeed, I do. I work with him regularly.

Senator **Bumpers**. Thank you very much, Dr. Hollinshead.

Dr. **Hollinshead**. Thank you, Senator.

STATEMENT OF M. JOYCELYN ELDERS, M.D., DIRECTOR, ARKANSAS DEPARTMENT OF HEALTH, ON BEHALF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, AND ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

Senator **Bumpers**. Now we are getting down to the real big hitters, Dr. Joycelyn Elders, M.D., director of the Arkansas Department of Health, American Public Health Association.

Dr. Elders, welcome this morning.

I have been watching you kind of shake up the carbide in Arkansas.

We are glad to have you.

Dr. **Elders**. Good morning, Senator. Thank you, and other distinguished members of this subcommittee.

I am Dr. Joycelyn Elders, director of the Arkansas Department of Health, and I am here today representing the American Public Health Association as well as the Association of State and Territorial Health Officers.

As someone who is on the front lines in the management and delivery of health services, I am acutely aware of the importance of adequate Federal support for public health programs. Federal appropriations are needed at a level which allows the Government to fulfill its commitment to preserving the public's health and meeting the Nation's special health needs. We believe that money spent for disease prevention and early treatment is an investment in the health of future generations, as the Senator just said, and of course, we are aware of his continued and long-term support of Public Health Service programs.

It is difficult for us, however, in public health service delivery to understand how such a cost effective program could be singled out year after year for reductions by the current administration. The administration's fiscal year 1989 budget proposal for health and human services would unquestionably undermine the health of our citizens. The budget deficit must be eliminated but the administration's approach to balancing the budget by reducing funds for preventive health care is counterproductive and fundamentally wrong.

Senator, in the past you and some of your colleagues in the Senate have assured adequate funding for important health programs. We look to you again to preserve and enhance the programs of the Public Health Service.

Because of the time constraints, we cannot mention all the important programs funded through the Centers for Disease Control [CDC]. However, ASTHO and APHA this year has chosen to focus on six of these programs. However, let me say that we believe at a minimum all of the non-AIDS related programs of CDC should receive $709 million, and the CDC AIDS activities should receive $697 million.

It is impossible to overstate the importance of immunizing our youngsters. Vaccines are among the safest, cheapest and most effective ways to prevent infection and communicable disease. We urge Congress to fund immunization activities at $165.5 million.

In the area of sexually transmitted disease, the past has shown a direct correlation between adequate funding for control of sexually transmitted disease and subsequent incidence rates. We recommend and urge the Congress to provide $166.5 million for CDC's sexually transmitted disease program.

We believe the administration's proposal for AIDS still falls short of meeting the challenges presented by this extraordinary epidemic. We support increasing AIDS funding to $1.9 billion.

We believe the administration's proposal to fund the preventive block at the fiscal year 1985 level is totally unacceptable. We urge you to fund this program at its authorized level for fiscal year 1989.

Congress appropriated $162 million for title X family planning in 1981. Accounting for inflationary increases alone, the current level of title X funding should be $210 million. Therefore, we strongly urge this committee to fund the title X program to at least $163 million.

Injury is the fourth leading cause of death among all Americans and the leading cause of death for children and young people. We urge this subcommittee to appropriate $20 million for the critically important injury prevention and control program to help reduce the injuries in our young adults.

PREPARED STATEMENT

Senator, we look to you to reverse the administration's strategy to save money and lives by adequately funding public health programs. These programs are not luxuries that can be eliminated or reduced without major consequences. On the contrary, they fundamentally affect the health and welfare of present and future generations.

Thank you.

[The statement follows:]

STATEMENT OF M. JOYCELYN ELDERS

Mr. Chairman and distinguished members of the Subcommittee, my name is Dr. M. Joycelyn Elders. I am the Director of the Arkansas Department of Health, and am here today representing the American Public Health Association, the oldest and largest public health society in the world.

Each year, the Association comes before this Subcommittee to seek federal appropriations at a level that will fulfill the government's commitment to preserving the public's health and meeting the nation's special health needs. We believe that disease prevention and early treatment are effective and relatively inexpensive in the long run. Investment in programs which deal with immunizations, AIDS, the Prevention Block Grant, Title X family planning, the control of sexually transmitted diseases and injury prevention and control substantially reduce the expenditures that otherwise would have to be made in the future.

Mr. Chairman, we know that you are familiar with these programs. In the past, you and some of your colleagues in the Senate have assured adequate funding for important public health initiatives. This year we look to you again to preserve and enhance the programs of the Public Health Service.

It is difficult for us to understand why measures that contribute to the public health in a cost effective manner have been singled out year after year for reductions (or level funding) by the current Administration. The Administration's FY89 budget proposal for health and human services unquestionably undermines the health of our citizens and health care system, with results that would be measured in wasted lives and dollars. The budget deficit must be eliminated, but the Administration's approach to health care is counter productive and fundamentally wrong. Those of us who are involved in the management and delivery of health care and human services are troubled by the abandonment of important public health goals as a result of cuts already enacted and the inadequate increases now being proposed for some vital programs.

APHA has chosen to focus its attention this year on immunizations, AIDS, the Prevention Block Grant, Title X family planning, the control of sexually transmitted diseases, and injury prevention and control. Because of time constraints we can not mention all the important programs funded through the Centers for Disease Control, however, we believe that at a minimum, all of the non-AIDS related programs of CDC should receive $700 million, and that CDC AIDS activities should receive $697 million.

Immunization Program

We urge Congress to fund the immunization activities, which include grants to states, funding for the new National Vaccine Program, the vaccine stockpile, and surveillance, research and technical assistance, at $165.5 million.

The Administration's budget argues that we have been 95% successful in our immunization efforts, but the budget request would have provided inadequate funding to complete the job. APHA's funding request of $146 million for state project grants would allow States to continue immunizing children at current levels and provide Haemophilus influenza vaccine to immunize children in their infancy.

We urge the Subcommittee to provide $.5 million in funding for the new National Vaccine Program. This Program will provide needed focus and direction at the Federal level on the development of both new and improved vaccines. Under such a program, a greater number of manufacturers are expected to enter the vaccine market and a greater number of vaccine products will become available to prevent disease, reduce reactions, and otherwise improve the public's health.

Past shortages of DTP vaccine and potential future shortages of other critically important childhood vaccines point out the need for a complete six month vaccine stockpile. In FY 83 it would have cost the federal government $19.9 million to establish a vaccine stockpile with a six month supply of vaccine. Today, due to increases in the cost of vaccine, completion of the same size stockpile will cost over $25 million. We urge you to provide, at a minimum, $10 million for the stockpile.

It is impossible to overstate the importance of immunizing our youngsters. Vaccines are among the safest, cheapest and most effective ways to prevent infections and communicable diseases. Immunization programs are estimated to return as much as $90 for every dollar spent. The introduction and widespread use of vaccines has resulted in dramatic declines in the incidence of childhood infectious diseases. Immunizing children today is far less expensive than paying for health and welfare costs attributable to childhood illnesses.

Sexually Transmitted Diseases (STD)

CDC estimates that more than 13 million Americans acquire a sexually transmitted disease each year. In 1985, the number of gonorrhea cases increased for the first time in a decade, penicillin resistant gonorrhea is out of control in certain areas of the U.S., and the incidence of congenital syphilis rose. In 1986, gonorrhea rates stabilized reversing the downward trend of past years. In FY 87 syphilis cases increased more than 25% nationwide over FY 86. In some cities syphilis increased over 100% in the past year, the greatest increases since the 1950s. Neglect of traditional STDs has reversed the momentum of the 1970s.

Over 1,000 babies will contract herpes at birth this year. Half of them will die, and half of the survivors will have serious birth defects. There were approximately 60,000 ectopic pregnancies in 1987, fifty percent of these fetal deaths were the direct result of sexually transmitted diseases.

Scientific evidence shows that persons with STDs, particularly those that cause breaks in the skin, are at increased risk for acquiring HIV infection. Control and prevention of these diseases are an important component in preventing transmission of AIDS.

CDC currently provides active leadership and support for national efforts directed toward the prevention and control of syphilis and gonorrhea. But there are few federal dollars presently going to chlamydia control, despite the fact that this STD is three times as common as gonorrhea. Chlamydial infections may result in infertility, miscarriage, infections in newborns, and ectopic pregnancy. In 1985, a national strategy to control chlamydial infections was developed. Chlamydia has replaced gonorrhea as the number one bacterial STD, but without sufficient federal funds directed toward its control, the problem will continue to get worse. Dr. Mason, Director of the Centers for Disease Control, testified before Congress that a national chlamydia control program would cost between $50 and $60 million. We urge this Subcommittee to provide $55 million for this purpose.

Despite the emergence of chlamydia, herpes, human papillona virus and the AIDS virus as priority STDs, in real dollars, the federal commitment has declined in the 1980s. Investment in STD control is cost-beneficial. For every $1 put into interrupting transmission of gonorrhea, $3 are saved in health care costs.

We urge you to provide $166.5 million in funding for the sexually transmitted disease program so that we can begin high risk chlamydia screening and other activities aimed at the control of herpes and human papillona virus. Finally, we ask that you instruct CDC not to reprogram STD resources for the AIDS program, but instead provide separate funds for AIDS activities.

Acquired Immune Deficiency Syndrome (AIDS)

By the end of 1991 there will be approximately 179,000 deaths from AIDS. Most of those 179,000 are already infected today. The World Health Organization has made an estimate that 10 million people are infected with the HIV virus worldwide. The Institute of Medicine recommended that the nation needs to build a $2 billion effort by 1990 if AIDS is to be brought under control.

For the first time, the Reagan Administration has recognized the seriousness of the AIDS epidemic and proposed a substantial increase in AIDS funding for FY 89. However, the Administration's proposal still falls short of meeting the challenges presented by this extraordinary epidemic.

Increasing AIDS funding in FY 89 to $1.9 billion would allow for needed education, risk-reduction and prevention programs. In the absence of a vaccine or effective treatment for this deadly disease, our only means of slowing or stopping the spread of infection is through education, risk-reduction and prevention programs that teach people how not to transmit or become infected with the virus. It would also provide needed funding for basic biomedical, epidemiological, psychosocial and other AIDS-related research programs. Lastly, this appropriations level of $1.9 billion would provide funding for some treatment programs for AIDS patients.

The Prevention Block Grant

Congress established the Prevention Block Grant in 1982 to provide States with funds for hypertension programs, rodent control, emergency medical and home health services, and a variety of other essential public health activities. The block grant allows states some flexibility in deciding what other public health programs to fund. More and more, states are relying on these funds to pay for critically important public health programs that they would otherwise be unable to provide.

If the Administration had its way, the Prevention Block Grant would be funded at FY85 levels. APHA believes this level of funding - a decrease after inflation -- is totally unacceptable. APHA urges you to fund this program at its authorized level for FY89.

Title X Family Planning Program

Title X of the Public Health Service Act provides the basis for our national family planning clinic network. This program prevents unintended pregnancies, reduces the need for abortion, and provides health services to medically underserved women. Approximately 800,000 unintended pregnancies - 425,000 among teenagers - were averted in one year as a result of the national family planning program.

In 1983, 5 million low and marginal income women received family planning services, including 1.6 million teenagers under age 20. For every dollar spent on teenage family planning services, $3 are saved in health and welfare costs.

In FY 81, Congress appropriated $162 million for the Title X program. Accounting for inflationary increases alone, the current level of Title X funding should be over $210 million. Therefore, we strongly urge this Committee to fund the Title X program at $163 million.

CDC Injury Prevention and Control Program

Injury is the fourth leading cause of death among all Americans. It causes almost half the deaths of children aged 1-4; more than half the deaths of children aged 5-14, and nearly four-fifths of the deaths of persons aged 15-24. Thus, injury is the leading cause of death among children and young adults.

For more than three decades of life, motor-vehicle crash injuries alone are the leading cause of death. The societal costs of motor-vehicle crash injuries are second only to those of cancer, among the other leading causes of death. Although injuries are responsible for the loss of more economically productive years of life than heart disease and cancer combined, the federal expenditure for research in injury control is approximately one-tenth of that for cancer and less than one-fifth of that for heart disease and stroke.

Substantial progress can be made in the reduction of the incidence of injury and its associated morbidity and mortality if adequate funding, direction, and support are given to a coordinated federal program of injury research.and control. We urge this Subcommittee to appropriate $20 million for this critically important public health program.

We look to you to reverse the Administration's strategy; to save money and lives by adequately funding public health programs. These programs are not luxuries that can be eliminated or reduced without major consequences. To the contrary, they fundamentally affect the health and welfare of present and future generations of Americans. It is not even penny wise--and it is certainly pound foolish--to underfund the prevention and early treatment of infectious diseases and other threats to the strength and productivity of our greatest asset, the America people.

Senator **Bumpers**. Thank you very much, Dr. Elders.

I must say I consider you Arkansas' expert on teenage pregnancies, and I assume that that is one place Arkansas is still No. 1. We do not enjoy that status, either.

Is that correct?

Dr. **Elders**. That is correct, Senator.

Senator **Bumpers**. Well, you know, around here, if we spent as much time on family planning and education on how to prevent unwanted pregnancies, as we do in voting on abortion, we might be able to prevent hundreds of thousands, maybe millions of abortions.

Are we making any progress on this problem in Arkansas?

Dr. **Elders**. Senator, I hope so. I want you to know that we are really working very hard with our schools to institute a comprehensive wellness program in our schools which would include sexuality education as well as contraceptives. We do not look at abortion as a means of birth control; we look at that as a failure. We want our youngsters to never have to deal with the subject of abortion, and we feel that with comprehensive education from kindergarten through high school and the availability of contraceptives where the children are will have a marked impact on reducing teenage pregnancy in Arkansas.

Senator **Bumpers**. How many AIDS cases have we had in Arkansas, Dr. Elders?

Dr. **Elders**. We have approximately 128 AIDS cases as of the end of April, Senator. So, so far it is not a major health problem for us in Arkansas. We are working very hard to educate our youngsters and to educate our minority populations as well as our, you know, our drug users and all of our high risks. We want all of our adolescents to be well aware of AIDS. We feel that this will be our next big wave or epidemic, if they do not understand the risks. And I really, we really feel that if we can inform them of the risks they are taking, that we can slow the progress of AIDS in our State.

Senator **Bumpers**. On the immunization program, you are preaching to the saved. I don't know what level of funding we'll be able to provide this year, but I promise you we are going to strive to accomplish a 6-month stockpile, particularly of DPT. All you have got to have is one big epidemic, and nothing in the stockpile, to make people aware of what a cost-benefit ratio really is.

You stated here that some people say that the benefit-cost ratio in the immunization program is as high as 90 to 1. I have never seen anything quite that high, though I have believed that. When Betty was immunizing all the children in Arkansas, I think I gave her $50,000 out of my emergency fund, and then she utilized the National Guard and the Extension Home Economists and extension service and everybody in sight——

Dr. **Elders**. Yes.

Senator **Bumpers**. And we were able to pull that off by using and coordinating both the public and private agencies. The State police even got involved in it, the National Guard, everybody.

Dr. **Elders**. We have been very proud of our immunization program in Arkansas. We noticed a slip the past 2 years, and as you know, we initiated a real effort to get back up to 90 plus percent immunizations, and this we hope to have completed by the end of the year.

Senator BUMPERS. Dr. Elders, one thing when Betty sort of became an expert on that and started educating me that a one-shot program was not the solution. The important thing was to put a program into effect where there was followup so that we knew children were going to be immunized year after year after year, and that all children were being immunized. I was going around boasting how we immunized 300,000 kids one Saturday. Well, that is all well and good, but that was not the real success story. The success story was putting in place the followup to make sure that future generations of children were immunized.

We have recently had several outbreaks of mumps. Incidentally, most of those mumps cases were in States that did not require mumps shots for school entry. That is what happens when people let their guard down on immunization.

I know there are a lot of people who object to mandatory immunizations, and I know that DPT shots can be very troublesome to any parent, but to do anything else is just the height of irresponsibility, and every pediatrician in the country will tell you that.

So I am preaching to you, but we both agree totally on this program.

Let me just say one other thing, that getting the money for immunizations now is very difficult.

I have been shepherding that appropriation through here ever since I came to the Senate, and you know what it was the first year I was here? Six months stockpile and all, $7 million. Some pharmaceutical companies have increased the price of their DPT vaccine by 3,000 percent in the past 10 years, and even though we have got this vaccine compensation program that we put in effect to relieve them of the liability they would otherwise sustain, Merck had the audacity to raise the price of their vaccine.

Dr. ELDERS. That is correct, Senator.

Senator BUMPERS. I am glad I do not own any stock in that company.

Dr. ELDERS. And you know, I think many of the children now, you know, what creates a further problem for us is many of our practicing pediatricians, because of the cost, over 80 plus percent of all immunizations that are given in Arkansas are given through the health department, and it will probably go up to 90 plus percent next year.

Senator BUMPERS. Yes.

Dr. Elders, you make a very impressive witness.

Where did Governor Clinton find you, anyway?

Dr. ELDERS. Well, Governor, I was on your task force for the status of women when I was first appointed. Dr. Bost recommended me.

Senator BUMPERS. We both get our information from the same source, then, do we not?

Dr. ELDERS. We both get our information from the same source, but I went to the University of Arkansas Medical School, and I was on the faculty as a pediatric endocrinologist from 1960 until I was appointed to be Director of the Health Department in October 1987.

Senator **Bumpers**. We are certainly honored to have you, Dr. Elders.

Thank you very much for being with us.

Dr. **Elders**. Thank you.

STATEMENT OF JOSEPH H. BATES, M.D., THE NORTH AMERICAN REGION, INTERNATIONAL UNION AGAINST TUBERCULOSIS AND LUNG DISEASE

Senator **Bumpers**. Our next witness is another Arkansan, an old friend, Dr. Joe Bates, International Union Against Tuberculosis.

Joe, welcome. We are glad to have you.

Dr. **Bates**. Good morning, sir.

Thank you for giving me the opportunity to come.

In addition to the written testimony that you have, I would like to expand just briefly about trends in tuberculosis and why we are concerned and what we can do about it.

In regard to the trends, the CDC has been monitoring new cases of tuberculosis for about 30 years in the United States, and beginning in the mid-1980's, the number of new cases, for the first time, began to plateau rather than decrease. Prior to that there were about 5 percent fewer cases per year. Beginning in the 1980's, mid-1980's, the number of cases plateaued, and then for the first time since it has ever been measured, in 1986 the number of new cases actually increased. That happened in Arkansas, that happened nationwide.

And the figures for 1987 are not in completely, but there is expectation that this trend will continue.

These new cases and this increase comes as a great surprise to the medical establishment, the scientific and public health community and we are very concerned. New cases arise from maybe three focal areas. The patients with AIDS are especially prone to develop tuberculosis, particularly the drug abusing population that gets AIDS, the minority, the immigrants from Asia, and the old people, and especially the old people in nursing homes are at great, great risk of developing tuberculosis.

Now, what can we do about all of this? Well, sadly, Senator, our methods for diagnosis and early detection and prevention of tuberculosis have not changed in decades. There is a vaccine for tuberculosis that began to be developed at the Pasteur Institute in about 1905. It began to be used in the 1920's. And that vaccine was developed by the most primitive methods, and totally lacking modern scientific technology. That vaccine is the vaccine that is used most today worldwide probably than any other vaccine. It is not used in the United States, and it is not very effective. It is certainly not effective at all in the United States and in many parts of the world. Yet we have maybe 10 million new cases of tuberculosis worldwide each year.

We also are using rather old and outdated, I would say, methods of diagnosing tuberculosis. We do not have a sensitive, accurate, rapid way to diagnose it. We ordinarily have to wait weeks, perhaps 3 to 6 seeks or so, before the diagnosis can be made.

There is an urgent need for a simple, inexpensive, reliable way to diagnose tuberculosis rapidly. Obviously if you diagnose it rapidly, you can do something about it.

So we are asking for your support for full funding of these tuberculosis project grants in the amount of $31 million to do two things: one, to help with the immediate epidemic that seems to be going on in these focal areas, and two, to support badly needed research in the development of vaccine and a new method of diagnosing tuberculosis.

PREPARED STATEMENT

We want to apply the modern techniques of molecular biology to these questions, and there is a very reasonable expectation, the scientific community is agreed on this, that money properly applied here would reap great dividends in a reasonably short time.

Thank you very much for allowing me to come.

[The statement follows:]

STATEMENT OF JOSEPH H. BATES

Mr. Chairman, members of the Subcommittee, I am Dr. Joseph H. Bates, Professor of Medicine and Microbiology at the University of Arkansas College of Medicine. I am appearing today on behalf of the North American Region of the International Union Against Tuberculosis. The IUAT-LD was established in 1920 and has 113 member countries including the United States, represented by the American Lung Association.

I welcome this opportunity to support increased funding for the Tuberculosis Control efforts of the United States Public Health Service. At the outset, Mr. Chairman, I would like to thank you for the Subcommittee's continued support for the Project Grants for Preventive Health Projects for TB. This program was reauthorized last year and an important new component added to that authority, provision for research activity. The IUAT-LD recommends that the full authorized level of $31 million be appropriated for the TB Project Grants and that monies be allocated through the set-aside for new research initiatives within the Centers for Disease Control and the National Institute of Allergy and Infectious Diseases. The Administration's continued underfunding of this program is shortsighted in view of the continuing problem of TB in the United States as well as worldwide.

TUBERCULOSIS MORBIDITY

When the U.S. Public Health Service TB Program was first created in 1944, there were 126,000 cases of TB reported in that year. By 1985, after four decades of TB control program activities, the number had declined to 22,201 cases. In 1986, however, that number increased to 22,768. This may, in part, be related to the occurrence of TB among AIDS patients--an issue I will review later in my statement.

So, despite the dramatic decline in morbidity and mortality we have seen over the past four decades, TB continues to be a significant public health problem. Of the 22,768 cases reported in 1986, 1,214 cases were in children under 15 years of age. The occurrence of TB in children is of particular public health importance because it is the most definite evidence that transmission of TB is currently occurring in the community.

TB takes its greatest toll on older age groups, minorities, and the socioeconomically disadvantaged. While 30.8 percent of the total population is

45 years or older, 56.2 percent of the TB cases in the U.S. occur in persons 45 years or older. The case rate for persons 65 years and over is 22.3 per 100,000 population compared to 8.5 per 100,000 for persons 25-34. Further, in 1986, 62 percent of all reported TB cases in the U.S. where among racial and ethnic minorities. The case rate is consistently higher for non-whites--26.2 per 100,000, almost six times higher than the rate of 4.5 per 100,000 in whites.

Tuberculosis and AIDS

A new area of concern for all of us is the recently noted relationship between HIV infection and TB. Clinical TB occurs as an opportunistic disease in HIV infected persons who were previously infected with the tubercle bacillus. Thus, HIV infection can activate TB in those previously only infected. This has caused the TB incidence to increase significantly in those areas of the country with the highest levels of HIV infection. HIV infected persons, therefore, are increasingly found in TB clinics and the TB, if not recognized and treated, may spread to those prolonged close contacts of the case.

TB PROJECT GRANTS

TB Project Grants were first authorized by Congress in FY 82 and most recently reauthorized in FY 88. Congress approved an appropriation of $7 million in FY 88. Administered by the Centers for Disease Control, the grant program provides cooperative agreements for TB control activities to state and local health departments in high incidence areas. The new authorization, for the first time, includes provision for research initiatives directed towards the prevention and control of TB with the ultimate goal of the elimination of the disease.

The Project Grant was developed to intensify programming activity--specifically outreach efforts--in high incidence areas. Outreach workers, usually from the community in which they serve, are employed for field follow-up and to directly observe therapy. This program activity has, according to CDC, resulted in savings of $15 to $20 million in hospitalization costs--25 percent of which would have been charged to Medicare or Medicaid. For example, Connecticut, Los Angeles, and Massachusetts report annual savings of $81,000 $500,000, and $250,000 respectively through the use of outreach workers and directly observed therapy in place of hospitalization.

More recently, TB Control programs have been facing new and more complicated problems. The full authorized level of $31 million is necessary to extend existing activities and develop new ones to address such concerns as:

- o Drug Resistant TB: Drug resistance has become a problem with outbreaks in several communities. Approximately 7 percent of new cases are found to have been caused by drug resistant bacteria. Therapy for this type of TB presents a highly complex treatment problem. The drugs used may be more toxic and less effective leading to patient compliance problems which require a significant increase in surveillance activities by the health department outreach workers.
- o TB and the Homeless: Recent reports of screening at selected clinics and shelters for homeless persons have found a prevalence of TB in 1.6 to 6.8 percent of the clients. These rates are 150 to 300 times the national rate.
- o TB and AIDS: To better understand the problem and design effective program strategies it is essential to establish and document several situations where there are critical needs for data, including:
  - o the proportion of the TB patients who also have AIDS
  - o the proportion of specific subpopulations with TB that have HIV infection
  - o the proportion of AIDS patients who have TB
  - o the relative risk of developing clinical TB among persons with both TB infection without disease and HIV infection without disease
  - o whether patients with HIV infection and TB are more or less likely to transmit TB infection to others
  - o the efficacy of current treatment and prevention regimens among patients with HIV infection and TB or TB infection.

Research Initiatives

TB remains a global problem of enormous dimensions. The World Health Organization estimates that at the present time, within a year, as many as 4 to 5 million new infectious cases of TB will develop. WHO also estimates that there are 3 to 4 million deaths from TB worldwide per year. Countries such as the U.S., that do not, comparatively, have large numbers of cases of TB contain a small part of the world's population. Those areas where a large proportion of the population of the world lives still harbor a great deal of

TB, and every year many people from such high incidence areas find their way to the U.S. Thus, we cannot hope to eliminate TB in the U.S. without planning and utilizing tools that would be useful on the world scale.

It is paradoxical that we can talk about millions of TB cases and deaths worldwide in one paragraph and eliminating this disease in the next, but to eliminate TB in the U.S. and worldwide will require far more intensified and widespread use of existing prevention and control methods, the development of new treatments, diagnostic and prevention technologies, and the rapid transmission of newly developed technologies to the field. Like smallpox, these are attainable goals. In 1985 the Centers for Disease Control, the National Institutes of Health, Pittsfield Antituberculosis Association, and the American Thoracic Society (medical section to the American Lung Association) cosponsored a conference to identify priority areas for research which might lead to an accelerated decline in tuberculosis morbidity and ultimately to the elimination of TB. A follow-up meeting further refined and developed the suggested initiatives. The National Institute of Allergy and Infectious Diseases is already reviewing applications for a new initiative in TB which was one of the results of this conference.

The reauthorization of the TB Project Grants has provided Congress with an unique opportunity to recognize the role of research in the attainable goal of eliminating TB. The IUAT-LD urges the Subcommittee to recommend use of the research set-aside in the authorization and to fund it at the fully authorized level.

* * *

In summary, Mr. Chairman, tuberculosis is an infectious disease which can be transmitted without regard to geographic or governmental boundaries. It is a public health problem not only of national but international scope. Its prevention, control and elimination require a strong commitment and the recogniztion of the role of the U.S. as a leader in the international fight against TB.

Senator **Bumpers**. Joe, thank you.

Is tuberculosis essentially a factor of unsanitary conditions?

Dr. **Bates**. No, sir; it has to do——

Senator **Bumpers**. You can live in the suburbs and get tuberculosis, huh?

Dr. **Bates**. It has to do with poverty, of course, but not sanitation per se. I mean by that——

Senator **Bumpers**. I do not understand that difference, Joe.

Dr. **Bates**. Well, it is not spread by direct contact or by touching. It is spread by airborne route, and you are more susceptible to develop the disease if you are poorly nourished or in some way debilitated. And poor nutrition, of course, is much more common among the socially deprived population.

Senator **Bumpers**. Do AIDS patients have a tendency to get tuberculosis because of their debilitated condition?

Dr. **Bates**. Their immunity is markedly impaired. They are already infected, particularly the minority population and the drug abusing population sort of go together, and then they go together in prisons also, as you know, Senator, and we really have a rich incubator of AIDS and tuberculosis in prisons, and it is an explosion that is about to happen, and it is going to be a very, very serious one.

Senator **Bumpers**. On a totally unrelated subject, and you may not know the answer to this—do we still have a high incidence of hepatitis in prisons?

Dr. **Bates**. Yes, sir; it is again part of the drug abusing problem.

Senator **Bumpers**. Joe, you know, when I was first elected Governor, one of the things that, Dr. Bost told me we ought to do is close the tuberculosis sanitorium at Booneville. Politically that was a very difficult thing to do, because we had been treating tuberculosis patients almost as lepers, and many people wanted them isolated away from the general population. We found out that that was not only foolish but that the cost of maintaining that sanitorium was much greater than it was to put these people in regular hospitals and pay for their care.

Dr. **Bates**. That is right, sir, and these project grants will permit the difficult problem of treating patients at home and in the community rather than in hospitals, again, which is a very cost-effective approach.

Senator **Bumpers**. If you had all the money you wanted, could you eliminate tuberculosis in this country?

Dr. **Bates**. There is a task force that has been established by the Secretary of Health and Human Services to eradicate tuberculosis in the United States. It is a very reasonable thing to talk about, and it could be accomplished. It could be accomplished in the world.

If this vaccine, an effective vaccine would be developed, I do not have to tell you about vaccines, Senator, I cannot think of a single more major scientific event in the world than that this would be accomplished, and it is something that is reasonable to expect in 10 years time.

Senator **Bumpers**. In 10 years?

Dr. **Bates**. A vaccine.

Senator **Bumpers**. Well, I had no idea that we were into a vaccine program in tuberculosis, or that the possibility existed that we could develop one.

Dr. **Bates**. Well, the United States has given precious little attention to this. It has been worked on in other countries, but the molecular biology, now, and the techniques and the scientific base for doing this really rest in this country and at the National Institutes of Health and their potential resources, with fairly modest appropriations, I think enormous impact could result.

Senator **Bumpers**. Just one second, Joe.

So we are not hospitalizing TB patients like we once did?

Dr. **Bates**. Very few are hospitalized. I would say 95 percent of the patients are treated at home or in community resources outside of hospital. The homeless are another problem, again, with tuberculosis. They are much more prevalent, and we are having outbreaks in these large custodial places where people sleep at night. These are little pockets of difficulty of control, but tuberculosis is widespread throughout the whole community.

I think Arkansas, Senator, is also No. 1 in new cases of tuberculosis.

Senator **Bumpers**. I was just getting ready to ask you that question.

How many cases did we have last year?

Dr. **Bates**. 425, I think, in 1987.

And before that, the year before it was less than 400, 300 something, 385, maybe, in that range.

Senator **Bumpers**. What was it last year?

Dr. **Bates**. 425.

Senator **Bumpers**. Good Lord.

Dr. Bates. There was a substantial increase and that is happening in many places.

In New York, in the city of New York, tuberculosis is——

Senator **Bumpers**. That is 7 percent of all the cases in the country last year, 6 to 7 percent. We have 1 percent of the population.

Dr. **Bates**. Yes, sir.

Senator **Bumpers**. And we have been 6 and 7 percent of all the tuberculosis cases in the country last year.

Dr. **Bates**. Yes, sir.

Senator **Bumpers**. Well, that is pretty alarming.

Dr. **Bates**. In Arkansas, the tuberculosis is coming from the old people.

As you grow older, unfortunately, your resistance——

Senator **Bumpers**. You become more susceptible to it?

Dr. **Bates** [continuing]. To tuberculosis falls off.

Senator **Bumpers**. Why are our old people more inclined to get it than other old people?

Dr. **Bates**. Well, I do not know that they are except we have as you know, a larger share of the old population, higher percentage.

Senator **Bumpers**. Joe thank you very much for being with us.

Dr. **Bates**. Thank you for allowing me to come.

Senator **Bumpers**. Give Patty my love when you see her.

STATEMENT OF FRED C. TINNING, PH.D., PRESIDENT, KIRKSVILLE COLLEGE OF OSTEOPATHIC MEDICINE, AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

Senator **Bumpers**. Our last witness is Fred Tinning, Dr. Fred Tinning, president, Kirksville College of Osteopathic Medicine, American Association of Colleges of Osteopathic Medicine.

Is it Tinning, is that correct?

Dr. **Tinning**. Yes, Senator.

I am Dr. Fred Tinning, president of the founding school of the osteopathic profession in Kirksville, MO, over 100 years ago, in fact. I am also chairman of the board of governors of the Colleges of Osteopathic Medicine, the American Association of Colleges of Osteopathic Medicine.

I am pleased to be here today to prevent the views of AACOM on fiscal year 1989 funding for program support for the health professions education, including student assistance. On behalf of AACOM, I want to thank the members of this committee for their continuing support of these important programs because continued support for these programs is important in that there is a physician shortage and a health profession shortage in general in many parts of rural America.

For example, we have underserved areas where our graduates of many of our colleges are currently serving across America; 58 percent of our graduates in Kirksville serve in communities of 75,000 or less. In fact, 38 percent of our graduates are in communities of 50,000 or less.

Over the years, osteopathic medical education has been committed to training family physicians to provide primary medical care services, especially to individuals who live in smaller communities. The majority of America's osteopathic physicians practice in general family practice settings, or one of the primary care disciplines. About one-half of them are practicing in communities with populations, as I indicated, of 75,000 or less.

In our area of northeast Missouri, we have a community that serves—our facility serves 23 counties. Some 23 percent of our population are over the age of 60, 22 percent are underinsured, 44 percent are uninsured, 42 percent are 150 percent below the poverty level. Federal health profession grants and student assistance programs have enabled us to build and expand our innovative education and training programs and have also enabled our students, who come from a variety of socioeconomic backgrounds, to have the opportunity to study osteopathic medicine. For example, Federal family medicine grants strengthen the ability of the Chicago College of Osteopathic Medicine to support faculty and staff who work with students and patients in the college's extensive ambulatory clinics, especially in the inner city.

The Southeastern College of Osteopathic Medicine in Florida uses an AHEC grant to meet needs, health needs, especially, of Caribbean and other refugees and migrant workers in that State.

My college at Kirksville provides a variety of health services as well as educational training to students through a network of rural satellite clinics in northeast and northern Missouri. The rural health initiative grant at Kirksville is one of the first in the Nation. In fact, we have one of the first four Women, Infant and

Children Programs in the Nation in northeast Missouri, serving the uninsured farm and other needy families.

We have recently been awarded an AHEC grant which will be used to provide support through our rural clinic network and our extensive extended care facility network for rural families facing economic crisis.

Many of our colleges, including the one at Kirksville, seek students with an interest in providing medical care to rural and underserved communities. Often these students are from the same rural areas, and many do not have the personal or family resources to pay the costs of osteopathic medical education. Many of our senior students report parental incomes of less than $10,000, and in fact, 50 percent of our graduates this past year come from families of incomes below $30,000.

The availability of a variety of Federal student assistance programs has made it possible for our colleges to offer an education that serves a broad spectrum of students. In fact, the majority of our students are first generation professionals. These educational opportunities would evaporate for many without a continued Federal commitment to student financial assistance programs.

Congress last year enacted new loan program payments under the National Health Service Corps and under the Indian Health Service. In exchange for services in medically underserved areas, primary care physicians can receive substantial loan repayment. However, current funding will only support 60 or 70 primary care physicians, and we have, for example, in the State of Missouri, 73.7 percent of the counties are served by osteopathic physicians, and we could replace 150 physicians right now who are currently retiring. The need is so very much greater, so we urge that the funding levels for fiscal year 1989 be substantially increased.

PREPARED STATEMENT

Mr. Chairman, these are my summary comments. I have additional material submitted for the record.

Senator BUMPERS. Your entire statement will be submitted for the record.

[The statement follows:]

STATEMENT OF FRED C. TINNING

My name is Fred C. Tinning, Ph.D. I am President of the Kirksville College of Osteopathic Medicine (KCOM) in Kirksville, Missouri, and I am also Chairman of the Board of Governors of the American Association of Colleges of Osteopathic Medicine (AACOM). I am pleased to be here today to present the views of AACOM on fiscal year 1989 funding for programs that support health professions education. These include programs of student assistance and also grants to health professions schools under Title VII of the Public Health Service Act. Let me acknowledge at the outset the work of this Committee to preserve funds for these valuable programs. All of us at AACOM appreciate your efforts.

It has been argued that many of these programs no longer need federal support because of an oversupply of physicians. This may be true for certain medical specialties and subspecialties, and some areas of the country are crowded with physicians. However, this is not the case in many parts of the country; for example, the rural, underserved areas of America served by graduates of the Kirksville College of Osteopathic Medicine. It is also not true that we have too many primary care physicians. Many more are needed. Programs of targeted support, like those under Title VII, are still very important and should be funded to the fullest extent possible.

Over the years, osteopathic medical education has been committed to training family physicians to provide primary medical care services, especially to individuals who live in smaller communities. The majority of America's osteopathic physicians practice in one of the primary care disciplines, or in associated fields such as emergency medicine. About half of them are practicing in communities with populations under 50,000. From its inception, our college at Kirksville has been dedicated to meeting rural health needs. At KCOM, 58 percent of our graduates practice in communities of 100,000 or less, with 38 percent in towns under 50,000.

Federal health professions grants over the years have enabled us to build and expand our innovative training programs and have also enabled our students, who come from a variety of socioeconomic backgrounds, to have the opportunity to study osteopathic medicine and be educated as primary care, family doctors.

For example, federal family medicine grants strengthen the ability of the Chicago College of Osteopathic Medicine to support faculty and staff who work with students and patients in the College's extensive ambulatory clinics. In Des Moines, Iowa, the University of Osteopathic Medicine and Health Sciences has a broadly-based training and service program offering free medical care to unemployed people living in the Des

Moines area. Here again, a family medicine grant helps support the staff in these clinics. The Ohio University College of Osteopathic Medicine is a key partner in an Area Health Education Center (AHEC) grant. This multi-disciplinary program has allowed the college to provide medical care to rural, underserved areas in southeastern Ohio, thus helping fulfill its legislative mandate.

Several colleges participate in AHEC programs and use that network to provide continuing medical education and other support services to health professionals who live and practice in rural areas and smaller communities. This includes not only physicians, but also nurses and other allied health professionals who are working there. This support is critical to keeping these health professionals working in these areas of need.

My college at Kirksville provides a variety of health services, as well as training to students, through rural satellite clinics in northeastern Missouri. The Rural Health Initiative grant at Kirksville is one of the first ever in rural America serving uninsured farm families. We have recently applied for an AHEC grant which, if approved, will be used to provide support for farm families facing economic crisis.

In all these examples, osteopathic medical students work in these settings as part of their clinical experience. Thus, they are exposed to the physician role models who encourage them to practice primary care. At the same time, they are learning medicine and providing services to patients. Thus, federal funds under Title VII of the Public Health Service Act not only expand our capacity to provide care to those who need it now, they also enlarge our capability to train new generations of primary care physicians so the we can be assured of meeting the medical needs of these communities in the future. Federal support is especially helpful because family medicine programs often do not generate sufficient patient care revenues to support fully this training component.

These examples clearly demonstrate the direct connection between the program funds that you appropriate in Washington and the education and services we are committed to providing at osteopathic medical colleges throughout the nation.

Given this success, it is indeed unfortunate that the partnership formed by the osteopathic medical schools and the federal government continues to be assaulted. Once again the President's budget proposes substantial reductions in funding for health professions grants. Were Congress to accept these cuts, our colleges would be hard pressed to maintain the kinds of programs I have been discussing with you.

Furthermore, AACOM itself might no longer be able to operate its federally funded Health Careers Opportunity Program (HCOP), which has been of great importance in identifying, recruiting and retaining students from minority and disadvantaged groups in osteopathic medical colleges, as well as other health professions schools. Numerous students who might not have entered a health professions career have been encouraged to do so.

Another area of significant need for targeted federal assistance relates to geriatric residencies and other geriatric training programs. The National Institute on Aging has estimated that by 1990 there will be a need for 8,000 physicians educated in the field of geriatrics. At present there are 700. Federal assistance is necessary to develop geriatric departments at our schools, to support geriatric residency programs and for faculty development if we are to meet the medical needs of our growing elderly population.

Biomedical science is a key element in the training of all physicians. Many of our faculty are deeply involved in NIH funded biomedical research which expands the frontiers of human knowledge and enhances our academic programs. This Subcommittee is well known for its commitment to the National Institutes of Health and we urge you to continue your support for their programs to the fullest extent possible.

Our colleges in Missouri, Ohio, and West Virginia have special dedications to providing family physicians in those regions. Therefore, they seek students with an interest in providing medical care in rural and underserved communities. Often these students are from these same rural areas, and many do not have the personal or family resources to pay the cost of an osteopathic medical education. Many of our senior students report parental incomes of less than $10,000 and 40 percent come from families with incomes below $30,000. The availability of a variety of federal student assistance programs has made it possible for our colleges to offer an education to this broad spectrum of students. These educational opportunities would evaporate for many without a continued federal commitment to student financial assistance.

There are several federal loan programs, but our students are most dependent on the Guaranteed Student Loan program, the Perkins Loan program, the HEAL program, and the Health Professions Student Loans. Over 86 percent of the federal funds used by our students come from these sources.

Mr. Chairman, I realize that the HEAL program is viewed by the government as a loan of last resort. However, as federal scholarships and other resources have become scarce, HEAL loans have become increasingly important to health professions students. The average senior osteopathic medical student's reliance on HEAL has grown significantly, from 43% of the total outstanding debt in 1983-84 to 62% in 1986-87. Average debt in 1986-87 was over $60,000. Any reduction in loan guarantees, such as proposed in the President's budget, could seriously affect the ability of many of our students to continue their education.

This increased dependence on loans is a concern to many of us in osteopathic medicine. The pressure to repay this enormous debt is great and may cause graduates to avoid lower paying primary care fields or the rural and other underserved areas of the country where compensation is often lower. Fear of that debt burden may even discourage some excellent candidates from pursuing an osteopathic medical education.

Reacting to these concerns, Congress last year enacted new Federal and State loan repayment programs under the National Health Service Corps (NHSC) and the Indian Health Service (IHS). In exchange for service in medically underserved areas, primary care physicians can receive substantial loan repayment. However, current funding will only support 60-70 primary care physicians. The need is much greater, with over 2200 primary care positions having been identified by the Department of Health and Human Services as required to meet the medical needs of these areas. We urge that the funding levels for fiscal year 1989 be substantially increased over the current level.

In conclusion, Mr. Chairman, we ask the Subcommittee to help us meet the need for primary care physicians to practice in America's smaller communities and other underserved areas by ensuring that grants under Title VII of the Public Health Service Act, federal assistance to students and programs for biomedical research are adequately funded in fiscal year 1989.

Senator **Bumpers**. Dr. Tinning, I certainly agree with you on the loans and the availability of money for medical students, which is one place that the President, I guess, and I disagree again.

But just one question. What is HEAL? I am not familiar. Is that the health loan program?

Dr. **Tinning**. Yes, it is.

Senator **Bumpers**. Is that just available to students going to medical school?

Dr. **Tinning**. Yes, it is, sir. Our HEAL students, our HEAL loans currently, for example, our students are borrowing a significant amount of money, and they are jeopardized because of the interest repayment that is required under the Tax Reconciliation Act. In addition, our addition, our students who are married are jeopardized with families because they do not receive the same amount of support from the HEAL loan. But it is a very important program.

As other Federal programs for student assistance have diminished, students have had to borrow from HEAL authority. We are facing an urgent need to replace our physicians serving in these small rural communities of 2,500 or 3,000, but the loans that these students, the debt service they have and the payback that they are demanded make it almost difficult to replace our retiring physicians.

Senator **Bumpers**. What is the enrollment at Kirksville?

Dr. TINNING. Our college has 132 students per class, 528 currently. There will be 1,800 graduates in our colleges of osteopathic medicine this year across the country, and as I indicated at least 50 to 60 percent of them will be going into smaller communities.

Senator BUMPERS. How many osteopathic schools are there in the country?

Dr. TINNING. There are 15 colleges of osteopathic medicine. We serve over 50 million patient visits a year. We have 200 hospitals across the country.

Senator BUMPERS. 200 osteopathic medicine hospitals?

Dr. TINNING. Yes, sir; approximately 200 osteopathic hospitals.

Senator BUMPERS. Where is your biggest one?

Dr. TINNING. Flint, MI, Columbus, OH. We have a big hospital in Normandy in St. Louis.

Senator BUMPERS. Why do you have separate hospitals from the regular hospitals?

Dr. TINNING. Historically there was a difficulty between the allopathic profession and osteopathic profession in the practice rights, and as a result, our hospitals developed separately. Many of our hospitals have been in smaller communities throughout the country where there was not health care facilities. As I indicated, about 58 percent of our graduates have gone into smaller communities across the Nation where there were no health care facilities. Several of those are closing——

Senator BUMPERS. How many years of training do you get before you get a degree?

Dr. TINNING. Four years past the bachelor's degree, plus 1 year rotating internship, and then if a person chooses a residency requirement, an additional 2 to 5 years, depending.

Senator BUMPERS. Do any general hospitals take your students for residency?

Dr. TINNING. Yes; they do, Senator. In fact, the chief resident in cardiology at Cleveland Clinic is one of my graduates who finished his internship at Flint Osteopathic Hospital, his general medicine residency there, and then was selected as a fellow in cardiology at the Cleveland Clinic.

We do not have the subspecialty programs and the specialty programs in our profession. The majority of our physicians are primary care physicians such as the family physician or the general internist or pediatrician or obstetrician.

Senator BUMPERS. Are osteopaths eligible for licensing in every State in the Nation?

Dr. TINNING. Yes; they are, in all 50 States and all territories.

We believe that we are a significant provider of first line health care across the country, and our relationship over the past 20 years with our brothers in the allopathic profession is increasing day by day as we make our commitment toward service to the American population.

Senator BUMPERS. What is the genesis of osteopathic medicine? What was the difference in the practice of osteopathy and general medicine?

Dr. TINNING. Our founder, A.T. Still, was an M.D., and so was his father. They were both C.C. Wesleyan preachers that came from the Civil War era and went in to serve the old Waukesaw mission in Kansas, the Indian mission, and then settled in Baldwin, KS, for a period of time.

A.T. believed that at that period of time the M.D. profession's concentration on disease, purgings and things of this nature, were foreign to what the Good Lord meant the human body for self-regulating and self-healing and prevention, and so he posited a whole theory that the, going back to Hippocrates, that the basis of osteopathy was on prevention and health rather than disease. And he also said that there was a very significant relationship between structure and function in the human body and the integrity of the musculoskeletal system which makes up 60 percent of the body's mass was important to the relationship to health. In other words, if you had a severe back problem or a lesion somewhere in the body, there could be a correlation between that and disease.

And so he began working in Baldwin, KS, on his theory, and eventually went up in 1874 to Kirksville, MO, his brother was just down the road in Atlanta, MO, as another M.D., and coined the entire concept and theory and practice of osteopathy.

Our school was opened in 1892. In fact, if I may, Senator, in that year we had as many as five hospitals in northeast Missouri. Our school at one time had 800 osteopathic medical students, and people were coming from all around the world. In fact, five trainloads a day used to come in to Kirksville to be treated by the old doctor, they called him.

Senator **Bumpers**. Do you do surgery?

Dr. **Tinning**. Oh, yes.

Senator **Bumpers**. Do you have a surgery department?

Dr. **Tinning**. Most definitely we do, yes. All of the modalities that the allopathic profession uses we do, but our concentration with the patient is on the holistic approach, prevention, and the quality of life, and we feel that that approach is another scientific approach that has been documented and is available, and many of our allopathic brethren are using it now significantly in their approach to health care.

Senator **Bumpers**. Thank you very much for being with us.

Dr. **Tinning**. Thank you, Senator, very much.

SUBCOMMITTEE RECESS

Senator Bumpers. The subcommittee will stand in recess until 9:30 next Tuesday morning when we will continue our public witness hearings.

[Whereupon, at 11:50 a.m., Tuesday, May 19, the subcommittee was recessed, to reconvene at 9:30 a.m., Tuesday, May 24.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1989

TUESDAY, MAY 24, 1988

U.S. Senate,
Subcommittee of the Committee on Appropriations,
Washington, DC.

The subcommittee met at 9:36 a.m., in room SD–192, Dirksen Senate Office Building, Hon. Lawton Chiles (chairman) presiding.

Present: Senators Chiles and Weicker.

NONDEPARTMENTAL WITNESSES

Senator **Chiles**. This morning, the subcommittee will continue with the fourth of 9 days of hearings of public witnesses, testimony focusing on programs funded by the Subcommittee on Labor, Health and Human Services, Education, and the 14 related agencies.

During these several sessions, the subcommittee will hear testimony from approximately 225 witnesses, the highest number yet to be heard by the subcommittee in a single year.

Because of the large number of witnesses, we have to request that each witness keep their oral testimony brief. You should be assured that your full statement will be included in the printed record.

In order to help us with the schedule, we are trying to use a green light-red light system, and, when the red light goes on, your 3 minutes have expired, the big hook comes down, and it picks you up. [Laughter.]

We will ask each of you to conclude your remarks so that each witness will have a fair and equal opportunity to be heard.

STATEMENT OF JOE W. GRISHAM, M.D., PROFESSOR AND CHAIR, DEPARTMENT OF PATHOLOGY, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, FOR THE FEDERATION OF AMERICAN SOCIETIES FOR EXPERIMENTAL BIOLOGY

Senator **Chiles**. Our first witness this morning is Dr. Joe W. Grisham, who will speak on behalf of the Federation of American Societies for Experimental Biology.

Welcome to the subcommittee.

Please proceed, Dr. Grisham.

Dr. **Grisham**. Thank you, Senator Chiles.

Thank you for the opportunity to testify on the fiscal year 1989 budget for NIH and ADAMHA. I want to highlight my written statement.

As past president, I represent the Federation of American Societies for Experimental Biology, a nonprofit organization of more than 29,000 working scientists, of which I am one.

We deeply appreciate the support that you and your committee have given to biomedical research over many years. This support has been the key in making the United States a world leader in biomedical research and applied biotechnology.

Mr. Chairman, we're in the midst of a period, a remarkable period, in biomedical research. Each day brings progress that allows us to better understand many diseases. But we face extremely difficult and challenging problems, such as AIDS, Alzheimer's Disease, and cancer. They will not yield to short-term solutions.

A long-term commitment to support of NIH and ADAMHA is necessary.

The investigator-initiated research project grant remains the cornerstone of biomedical research, we believe. We, at FASEB, appreciate the subcommittee's decision to cite in the 1988 report the number of grants that we wish to see funded, and we urge you to do so again in fiscal year 1989.

Mr. Chairman, FASEB supports the 5-year plan of the ad hoc group for biomedical research to improve the Nation's biomedical research capacity. Implementation of the second year of the plan in fiscal year 1989 would require an NIH budget of $8.2 billion, and an ADAMHA budget of $716 million.

The President's recommendation of $7.1 billion for NIH for fiscal year 1989 will not maintain the level of NIH research. Now, $7.6 billion appears to be the bare-bones, maintenance budget that will allow current biomedical research, at a minimum, to be sustained.

Mr. Chairman, we FASEB scientists did not bring you these recommendations lightly. We recognize the budgetary dilemma that you face. We believe that the continuation of the biomedical research programs, at least at their current level, is essential for the welfare of the American people.

PREPARED STATEMENT

The cost is substantial, but we hope that you will be determined to press forward with this humanitarian work.

I thank you for your consideration.

I will be pleased to try to answer your questions.

[The statement follows:]

STATEMENT OF JOE W. GRISHAM

I am Dr. Joe W. Grisham, professor and chairman of the Department of Pathology at the University of North Carolina in Chapel Hill. I am representing the Federation of American Societies for Experimental Biology (FASEB) at today's hearing. FASEB is a nonprofit organization whose purpose is to develop and disseminate new knowledge in the life sciences through its meetings, publications and programs. FASEB has more than 29,000 members who are working scientists at universities and in government and industry.

FASEB deeply appreciates the support that you and your Subcommittee colleagues have given to biomedical research over many years. This support has been the key to our progress against disease and to making the United States a world leader in the field of biomedical research. In particular we are very grateful for the funding support you provided biomedical research for fiscal year 1988.

We are in the midst of a remarkable period in biomedical research. Each day brings new headlines that attest to our progress in biology and in dealing with disease. We are reaping the benefits of research investments made 10, 20 or 30 years ago. These investments brought us such advances as antibiotics in the 1940's and are bringing us the fruits of biotechnology today. We were quick to understand the AIDS virus because of the science base that had been built up over the years.

But we face extremely difficult and challenging problems, problems such as AIDS, Alzheimer's and cancer. Research efforts continue on developing treatments, cures and preventive measures for these afflictions that cut broadly and deeply into American society. They may not — likely will not — yield to short-term solutions. A long-term commitment of support from NIH and ADAMHA will be required to unlock the knowledge that will enable us to cope with these problems.

This of course will continue to place emphasis on the investigator-initiated research project grant which will remain the cornerstone of biomedical research. FASEB has been a leader among scientific societies in urging Congress to specify the number of grants it wishes to fund in any given year. We deeply appreciate the Subcommittee's decision to cite the number of grants in its fiscal 1988 report and urge that it do so again in fiscal 1989.

Let me explain why such specificity is needed. First, it is important to investigate a multiplicity of research opportunities at a wide variety of basic and applied levels. One can never be certain what areas of research will have the greatest relevance in the long run. The pressures for attention to the illnesses of the moment are understandable. However, it also needs to be understood that creative lines of inquiry off the mainstream often lead to profound contributions. To carry out this work requires the assurance that a sufficient number of grants will be available to research scientists.

Second, specifying the number of grants sends an important signal on priorities and achievable goals as both the Executive Branch and Congress work to reduce the deficit. And third, it lets the research community know the number of research scientists that can anticipate support. This can be a critical factor for young people trying to decide whether there is a future career in biomedical research.

After years of sending mixed signals about its priorities in medical research, the Administration has now submitted a budget that proposes an increased appropriation for NIH in FY 1989. While we are pleased that it has done so, the request of $7.1 billion is insufficient to maintain the momentum of research that has been built up over recent years.

We are advised that it will take $7.6 billion, or some 14 percent more than the President has requested, simply to maintain NIH's level of effort. This is due not only to inflation but also to the rising cost of modern research which includes increasingly complex techniques, more expensive materials, more sophisticated equipment and highly trained staff.

But we want to do more than simply maintain the current NIH level of effort. New research leads develop all the time and following them up can be critical to developing therapies that will save lives and reduce suffering. NIH and ADAMHA must be in a position to take the fullest possible advantage of such research opportunities as they become available. This requires appropriations for biomedical and behavioral research which assure that new possibilities can be explored in a timely fashion.

The Ad Hoc Group for Medical Research Funding, of which FASEB is a member, has proposed a five-year blueprint to build the nation's biomedical and behavioral research capacity to the point where it can fully capitalize on current scientific opportunities and enhance future research prospects. One goal of the five-year effort is to achieve a 50 percent award rate for research project grants for NIH and ADAMHA by fiscal 1992. Our recommendations reflect the second year of the five-year plan.

For fiscal 1989, we believe it will require $8.2 billion for NIH to accomplish the objectives the Ad Hoc Group has set out. Such an amount should be sufficient to fund about 7,400 new and competing research project grants (a 41 percent award rate) while maintaining current program balance for other NIH activities. The recommendation would allow training to grow to 11,350 positions, as recommended by the Institute of Medicine, and assumes an increase in pre- and post-doctoral stipends.

It also would permit necessary expansion in other areas, particularly the important biomedical research support grants program. The Group also believes that an additional $250 million should be made available for the repair, renovation and replacement of deteriorating extramural research facilities, including facilities for care of laboratory animals. It recommends that these appropriations not be made at the expense of other worthy programs in the health and educational field.

For alcohol, drug abuse and mental health research and research training, the Ad Hoc Group is recommending a funding level of $716 million. This would fund about 650 new and competing research project grants, or some 35 percent of all approved applications, and provide for increased research training, facilities and equipment, and new initiatives.

The stepped up support for ADAHMA is particularly important given the severe consequences of alcohol abuse and alcoholism, the abuse of drugs and the problems of mental illness. The additional funds would help to fill the need for more qualified scientists at the research and clinical research level. They would help to reduce research barriers caused by inadequate facilities and the lack of modern instrumentation. One area of particular importance is providing the scientific foundation for genetic and epidemiological research on alcohol, drug and mental disorders.

We do not lightly bring you these recommendations, given the budget dilemma you face. But we recognize that in setting priorities, decisions can be made to move ahead with programs that are absolutely essential to the welfare of the American people. We believe biomedical research belongs in this category. The cost is substantial, the timing perhaps is inconvenient. But we hope you will agree that our determination to go forward with this humanitarian work must be undiminished. I thank you for your consideration and will be pleased to answer any questions.

Senator **Chiles**. I thank you, Doctor.

Somehow we've gotten ourselves on a wheel and we are like the squirrel in the cage. It is awful hard to keep up with it. If you look back to 1981, and you see everything that has happened during this administration, all the cuts that have been made, and then you look at the programs in NIH, you see the area in which the Congress has resisted all of those cuts every year; 8.5 percent would be a 27-percent increase over last year, and no matter what we do, we're not keeping up with the pace.

Well, one reason we're not keeping up with the pace is the damn pace is so fast. I mean, at some stage I think you have to recognize that there are other needs out there that we have been paying attention to and we will continue to do so.

But, no matter how fast we run, we ain't running fast enough.

Dr. **Grisham**. It is a severe dilemma and we recognize that, Senator.

Senator **Chiles**. It sure is. It has been compounded this year when we find that our share of the pie has been cut by the Appropriations Committee, and there is no way, with the kind of apportionment that we now have, that we are going to be able to approach the figures that you are talking about.

We thank you for your testimony.

Dr. **Grisham**. Thank you, sir.

STATEMENT OF THOMAS D. POLLARD, M.D., PRESIDENT, THE AMERICAN SOCIETY FOR CELL BIOLOGY

Senator **Chiles**. We will hear next from Dr. Thomas D. Pollard, president of the American Society for Cell Biology.

Dr. **Pollard**. Good morning, Mr. Chairman and members of the subcommittee.

Senator **Chiles**. Good morning, Doctor.

Dr. **Pollard**. Thank you for this opportunity to testify on the fiscal year 1989 NIH budget.

I am Tom Pollard. I am director of the Department of Cell Biology at Johns Hopkins Medical School, and president of the 6,000 member American Society for Cell Biology.

Like the other witnesses, first, let me thank you for your past support of the NIH.

Today I want to make one main point, and that is that our ability to deal effectively with the diseases that disable and kill our citizens depends on maintaining and expanding vigorous research in the basic biological sciences.

Let me give you a personal example.

I am an M.D., and 16 years ago I decided I could have a bigger impact on patient care through research and teaching than by treating individual patients. Six months ago, I became a colon cancer patient myself. This alarming turn of events led me to read all that I could about this serious disease that affects 1 out of 20 of our citizens.

This review reaffirmed my conviction that effective treatments for this and many other common diseases will occur only when we understand how normal cells regulate their growth and behavior.

Now, basic scientists are optimistic that we can contribute this knowledge because we are on the verge of understanding, at the molecular level, the fundamental processes of life.

Through years of hard work, largely financed by the NIH and supported by your committee, many important general principles are starting to emerge. For example, our ability to see each other here today is based on the same type of biochemical machinery that amoebas use to talk to each other outside in the lawn. So, clearly, life processes are based on a complex, but limited, repertoire of molecular mechanisms.

Now, a grand synthesis of the basic concepts of life will emerge during the next 10 to 20 years providing—and this is where you come in—that we maintain our momentum in the supply of bright young people entering medical research.

Now, such a grand synthesis should make the causes of most diseases self-evident, and will provide for the first time a rational approach to their prevention or cure. To this end, cell biologists joined the ad hoc committee for medical research funding to recommend a fiscal year 1989 appropriation of $8.2 billion, an appropriation which you find difficult, but which is essential for maintaining this momentum and reaching our ultimate goal.

In closing, I want to call particular attention to two serious concerns. The first is the erosion of individual NIH research grants by ever-larger administrative cuts, referred to as "downward negotiations," that are made after peer review committees, such as the one that I chair at the NIH, have cut proposed budgets down to the bare minimum necessary to do the research. These administrative cuts can cripple a research program, and I urge you to push for an NIH budget large enough to preclude this practice.

A related concern is that underfunding the NIH could rapidly lead to a loss of confidence in the system and discourage talented young people on whom the future depends from entering the field. This has already occurred in Great Britain, due to budgetary cuts of their medical research system, and it will be a great tragedy if the same thing were to occur here.

I thank you for your attention and hope you will be able to give the NIH budget a high priority among the many difficult decisions you face in this fiscal year.

PREPARED STATEMENT

As a long-term public health investment for our people and people throughout the world, medical research is an appropriate and ultimately cost-saving Federal responsibility.

Thank you.

[The statement follows:]

STATEMENT OF THOMAS D. POLLARD

Mr. Chairman, members of the Subcommittee, it is my privilege to testify before you on the fiscal 1989 National Institutes of Health budget as the representative of over 6,000 working scientists in cell biology. I am Tom Pollard, Professor and Director of the Department of Cell Biology and Anatomy at Johns Hopkins Medical School, and President of the American Society for Cell Biology.

The enthusiasm of this Subcommittee over the years for the work of NIH has resulted in a biomedical research enterprise that is the model for and envy of the rest of the world. My colleagues and I thank you for your farsighted support and your appreciation for basic research as a national, longterm investment.

We understand that you are under enormous pressure to reduce the federal deficit and that particularly this year, because of the deficit reduction agreement, federal dollars for domestic programs are extremely tight. We also know that this Subcommittee is responsible for funding other programs with as compelling a mandate as NIH's mission to explore the nature of life and health and alleviate disease. These can be difficult choices.

We believe, however, that the appropriate role of the scientific community in regard to Congress is to recommend an NIH budget based on available scientific opportunities in biology and adequate to exploit these potential opportunities. For this reason, we join with the Ad Hoc Group for Medical Research Funding in recommending a fiscal 1989 appropriation for NIH of $8.2 billion including AIDS funding. This proposed budget would support about 7,400 new and competing grants and the 11,340 trainees recommended by the Institute of Medicine. The recommendation would also allow for an increase in pre- and post-doctoral stipends, the biomedical research support grants program, cooperative clinical research, minority biomedical research support and the NIH intramural program.

The proposed budget represents a substantial increase for NIH, but it is a very small fraction of the nation's total health care bill. The importance of the unique federal role in the support of the basic biomedical sciences cannot be overstated. As a longterm, public health investment for our people and people throughout the world, it is an appropriate and ultimately cost-saving federal responsibility.

Basic biomedical research, like any creative process, is not always a predictable business. Biology is a magnificent puzzle with a large number of complex pieces that have sometimes unexpected shapes and many possible ways of fitting together.

Fortunately, through years of hard work in cellular and molecular biology, many important general principles have started to emerge. Many of us feel that a grand synthesis is likely to emerge during the next one or two decades, providing that we maintain our momentum and the supply of bright young people entering the field. Such a synthesis should make the causes of many diseases self-evident and provide a rational approach to their prevention or cure. Without such a synthesis, medical treatment remains largely empirical and frequently falls short of its goal of a definitive cure.

The individual investigator-initiated research grant is the core of this national investment in biological research. The men and women supported by these grants produce the increments of knowledge we need for the great discoveries which will allow us to grapple with cancer, heart disease, AIDS and other afflictions. Not only do individual investigator-initiated research grants push the peripheries of biomedical science outward by harnessing the creative power of our best scientists, but many of these people work in a university setting where they train the next generation of investigators.

Because biology is a web, the knowledge deficit that exists when good ideas go unexplored because of a lack of funds or go incompletely explored because of inadequate funds does not affect just one discipline. The deficiency ripples through basic biology; other discoveries are not made, some human suffering persists unalleviated and health care dollars go unsaved.

I would like to call particular attention to our deep concern about the erosion of individual grant budgets by ever larger downward negotiations which NIH administrators are forced to make because of inadequate funds. Despite the 7.7% boost in NIH's fiscal 1988 appropriation, NIH Director James Wyngaarden has told this Subcommittee that the fiscal 1988 cuts are averaging 11% for new grants and competing renewals and over 7% for non-competing continuations. "Downward negotiation" is a gray, bureaucratic word and even the fact that some grants have endured cuts of over 15% from the Council-recommended amounts does not really convey what happens when grant budgets are sliced this deeply.

Director Wyngaarden predicts that even with the 7% increase contained in the President's budget for NIH in fiscal 1989, average cuts of over 13% will occur for new grants. NIH says that, given the number of grants it is supporting and the high biomedical rate of inflation, it needs a 14% increase, a budget of $7.6 billion, to maintain fiscal 1988 activities in fiscal 1989. Let me make the situation clear by reminding you that peer review committees carefully evaluate budgets in grant applications and eliminate all unnecessary expenses. Consequently, administrative downward negotiations are really arbitrary cuts in minimum budgets that can cripple a research program through inadequate funding.

Large downward negotiations also send a negative signal to aspiring scientists that federal funding is not only hard to obtain, but slippery once grasped.

The Subcommittee should also be aware that at a time when Congress is concerned about the state of the nation's scientific infrastructure, hefty cuts in new grants can be counterproductive. Nearly 18% of the average new grant's budget is for equipment, far outstripping equipment funds for competing renewals (8%) and noncompeting continuations (2%). Keeping our laboratories updated is essential if the U.S. wants to continue to be the world leader in biomedical advances.

There is an element of faith involved in making this kind of investment for the nation, but today we are seeing the unforeseeable payoff from the investment made in the work of individuals twenty and thirty years ago. The results of the investment this Subcommittee makes in NIH for FY 1989 may only be clear five, ten, twenty or thirty years from now and may be equally unforeseen. However, we cannot say it better than your colleague Rep. Dave Obey did in the Washington Post last year: "Our best defense against AIDS and all other disease is the expansion of our knowledge about basic human biology. When we fail to support the research necessary for that expansion to take place, we do not have an effective program or strategy to combat AIDS because we are trying to build walls and windows while failing to build a foundation."

Thank you again for this opportunity.

Senator CHILES. I thank you, Doctor.

All of what you say makes great sense. In 10 to 20 years, it would be wonderful if we could do that. I won't be here to put the funds in that.

This is my last year. I have run the cage for so long that I've burned out now, and I'm going to have to sit back and cheer for somebody else to pick that up. But I have great confidence that we will continue to keep the progress going.

Dr. POLLARD. Thank you.

STATEMENT OF DONALD PRICE, VICE PRESIDENT FOR RESEARCH, UNIVERSITY OF FLORIDA, REPRESENTING THE ASSOCIATION OF AMERICAN UNIVERSITIES AND THE NATIONAL ASSOCIATION OF STATE UNIVERSITIES AND LAND GRANT COLLEGES

Senator CHILES. Now we will hear from Dr. Donald Price of the University of Florida, representing the Association of American Universities and the National Association of State Universities and Land Grant Colleges.

It is good to see you, Don.

Dr. PRICE. Hello, Senator Chiles, members of the committee, I am vice president for Research at the University of Florida, and I am pleased to have the opportunity to be here today to speak on behalf of these associations.

Mr. Chairman, I am pleased that last Friday night we had a chance to honor you a little bit for the many things that you have done for us and hope you can begin to understand how much we Floridians appreciate the long and effective leadership you have provided in the U.S. Senate.

I know members of this committee and friends in the Congress and all over the country share with me the sadness that you are going to soon be leaving a post that you have served with such great distinction.

I am here today to support the budgets of the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration.

I know the budget is tight. We all know that. I know that most of you probably feel you need the wisdom of Solomon to know where to cut, where to spend, where to appropriate, and where to set the priorities. It is not an easy job, and we appreciate the sincerity with which you go about the important task of setting the spending plan.

We want to encourage you to do what you can to support the research that can lead to cures of all kinds of dreaded health problems. The academic research community can accomplish much in these next few years. There is much to be accomplished.

I think, and maybe this has been said for years, that we are on the threshold of being able to solve many dreaded diseases.

I know, Mr. Chairman, you had the opportunity to see first hand some of the work that is going on in nerve regeneration. A breakthrough in that would be such a tremendous blessing to so many people around the country, to be able to rejoin separated nerves and bring life to now motionless and often painful limbs.

This is but one area of research where we have great hope for the future.

As you consider the fiscal year 1989 funding for NIH and ADAMHA, we wish to emphasize the importance of avoiding major disruptions in funding, and call your attention to some specific programs and special needs.

The BRSG program is unique and has been tremendously effective and important in supporting scholarly scientific research, new startup programs, a critical piece of equipment here and there, and has supported young, promising scientists. Those are just a few of the things that that program has allowed universities and young scholars to pursue.

The administration has sought for many years to reduce or eliminate this program, and Congress has had the wisdom and the will to keep it. We hope that you will have it this year, as well.

Research facilities is another critical area. You know, as we have talked many times, of the critical problems that we have at our university and that we have in universities all over the country.

The NIH committee has prepared a report, and I understand there may be a bill forthcoming within the next 2 or 3 months related to facilities for biomedical research.

We know that it is probably not possible to fund this at the needed level. But even a small, initial program of $150 million or $200 million would relieve some of the pressure at institutions, possibly relieve some of the pressures that Members of Congress feel to earmark funds for facilities.

Investigator-initiated research continues to be the cornerstone of scholarly research programs. A reduction in grants, either in the direct or indirect cost categories, harm this important research program.

It will be impossible for universities to make up the cuts of the reductions that come from these individual investigator funded programs.

PREPARED STATEMENT

Let me just close with a quote of a brief resolution of the AAU, related to use of animals in medical research. I see that my time is up and that is in my written material. I refer it to you.

It does state our position on the use of animals for research.

Thank you.

Senator CHILES. I thank you very much, Doctor Price.

[The statement follows:]

STATEMENT OF DONALD PRICE

This statement is submitted in behalf of three collegial associations with strong commitments to academic research and in particular medical research. It contains our views on the budgets for NIH and ADAMHA.

For a number of years, witnesses representing our organizations and the institutions they embody have come before your subcommittee to note their apprehensions and anxieties over the proposals submitted to Congress in the annual budgets of the Administration. This year, while the Administration proposal is a major improvement over previous years, it falls short of a current services budget and does not come close to meeting the available opportunities in biomedical research. However, before commenting on the Administration's budget,we want take this opportunity to stress the gratitude and admiration of our members for this Committee and your colleagues in the House and Senate who join you annually to produce appropriation levels that are responsive to the needs of the people of this country.

NIH and ADAMHA

We are mindful of the fiscal pressures that you have faced in recent years and face now, and respect ever the more your successful efforts in producing sound funding for federal health programs. As you consider FY 1989 funding for NIH and ADAMHA, we wish to emphasize the importance of avoiding major disruptions in funding and call your attention to some specific programs and special needs.

The BRSG program is a unique mechanism that has never been supported at its authorized levels. The entire research community supports funding this program because of its importance to research and the support of young research scientists. Frequently, these relatively small grants enable an institution to purchase a small piece of equipment necessary for research to begin or continue. Further, it is frequently the first support for new and highly promising scientists who have to prove themselves over some years before successfully competing for NIH support. The Administration has sought for many years to reduce or eliminate the program while Congress has shown its understanding of the significance of the program and restored funds. We ask again that these funds be maintained.

Another area that causes consternation in the biomedical research community is the state of research facilities. In last year's appropriations legislation this Committee asked the NIH to convene a group to make recommendations to the Congress on how to address the research facilities deficit. We understand the Committee will receive in the near future the final report from the Department. Members of the university research community who served as members of this study report a unanimous consensus that the NIH must begin a new facilities program if the extramural community is to be able to continue to host federally funded research. Further, the group recommended a matching program and noted that direct federal funding of a merit-based facilities program is the most efficient and fairest approach to the problem.

Our associations have watched individual institutions use more political means than had been the case previously to secure research facilities. This has not eased the problem very much while generating a debate in the Congress and in the community. The leaders of most of the institutions that have approached the Congress for individual assistance would testify that were a competitive program available to obtain research facilities, they would immediately drop any efforts to secure them through a process of set-asides or earmarkings in different legislation.

We recognize that given the extraordinarily large need and the pressures on the budget, the Congress is not able to resolve this problem immediately, However, we also recognize that even a small initial program of $150-$200 million would relieve the pressure on the institutions and on Members of Congress.

The Senate Committee or Labor and Human Resources has reported a bill to reauthorize the NIH. That bill contains a title that creates a new facility program. Should that legislation be successfully enacted into law, we urge this appropriations committee to initiate more funding for the facilities title.

Training always will remain a major concern of our educational institutions. We know that the conduct of the nation's biomedical research has become more complex and requires more technology and is ever more personnel-intensive. Our institutions have trained a cadre of scientists prepared to look for answers to essential questions regarding human health. Certainly, in these times of health demands and even crises, we belive that the nation requires no less than a maintenance of effort in training and preferably an enhancement of programs.

In the Administration's proposals and NIH and ADAMHA practice, there lies an unstated belief that the sponsor of research can get away with underfunding the project--that somehow the host institution or the scientist will come up with the funding to carry out the research. We understand that over the years it has been common for the grant support level, after the study sections have adjusted the requests downward, to be reduced by another few percentage points. Multiplied many times over in universities, which host dozens of projects, this system compels institutions to subsidize an ever-increasing portion of federally sponsored research.

The members of the scientific community, quite understandably, want to see a maximum number of fine research scholars funded. This requires a larger number of grants. The administrators in this program are caught in a conundrum: the increase in their number instead of being a boon to science becomes an oppressive burden. The answer is not simple, though it is obvious: additional funds. Clearly, we must be responsible in our requests, noting, Mr. Chairman and Members of the Committee, that whatever your own wishes, you, too, must operate within restrictions. In this context of difficult decisionmaking, we ask you to recognize three points. First, reductions in grants, either in the direct or indirect cost categories, harm that research. Second, attempts to distinguish between the two categories are specious. The two make up the totality of the research project, and that project can be crippled by severe cuts in either. Third, investigator-initiated research remains the cornerstone of the research effort. Still, it is essential to provide support for the entire spectrum of NIH programs and mechanisms including training, clinical trials, the BRSG program, support for graduate and postdoctoral training, facilities support as well as the intramural program itself, NIH. All of this applies exactly the same way for ADAMHA. We endorse the proposal of the Ad Hoc Group on Medical Research and call the section on infrastructure to the Committee's attention

We wish to include for the record a recent resolution of the AAU in regard to the use of animals in research. This resolution also has been adopted by the NASULGC. This statement follows a recent resolution by the American Medical Association as well as a strong statement by the Assistant Secretary of Health, Dr. Windom. We are aware that your Committee hears different views from those opposed to the use of animals in research and believe it is necessary to state unequivocally the facts: the use of animals is essential to continued progress in medical research. The AAU resolution states:

> "We are members of an association of universities devoted to the pursuit of research in the public interest. It is our belief and experience that the use of animals is essential for the continued success of biomedical research. Efforts on the part of those who oppose such research have already impeded the conduct of research and have led to significant human cost and delays in the progress of research. Newly proposed restrictions and paperwork requirements threaten to restrict progress even more seriously. We affirm the commitment of our member institutions to the humane care and ethical treatment of research animals, and to a broadened public understanding of the need for animal research in the improvement of human and animal health and welfare.

In sum, while we cannot be indifferent to the extraordinary restraints on the federal budget this year, neither can we overlook the demands of the citizens for more prevention, more cure and generally enhanced physical and mental health for their families. We would be pleased to assist you in any way in trying to achieve this balance.

STATEMENT OF FRANK E. SAMUEL, JR., PRESIDENT, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

Senator CHILES. Now we will hear from Mr. Frank Samuel, president of the Health Industry Manufacturers Association.

Mr. SAMUEL. Thank you, Mr. Chairman.

This is our association's first appearance before your subcommittee to support the NIH research funding request. We do it because we have a great concern and a great interest in the fundamental commitment to the investment in good health of the American people.

Our companies do not benefit directly and do not participate directly in NIH research. Our companies make the tools by which much diagnostic and therapeutic health care is actually achieved.

Implants, like orthopedic implants, pacemakers, heart valves, monitoring machines, M-R scanning machines, diagnostic tests for AIDS and other conditions, home care products, you name it in the health care system, and one of our companies produces it.

Many of our companies are quite small, employing just a few dozen or a few hundred people. A few of them benefit from the SBIR program at NIH. Although we are pleased with that program and support it, it is not really because of the SBIR program that we are here today. It is because the commitment to NIH research, which has been a hallmark of our country and one of the great achievements of this committee, is a sign of the commitment not only to human capacities and maximizing human capacities, but, in a more economic sense, to our entire international competitiveness.

We are hearing much talk at all levels of society about the need for investing in education, and I think much of that talk is justified. But I think good health is a prerequisite to making the most of one's education, and investment in basic research, evidenced by NIH, by the commitment to NIH, is a sign of the importance of the investment in human capacities that is represented by much of the current debate on education.

We realize the pain that the subcommittee and its staff will have to suffer in deciding where to cut the various requests is significant. I guess we would encourage you, if you can't run fast enough, at least to keep on running, and encourage your successors to keep on running.

In closing, I think we are saying that, although we are a society and an association for manufacturers, we are not a society for the preservation of iron lung manufacturers.

PREPARED STATEMENTS

I want to be representing 10 years from now or 20 years from now a group of companies making new products, making them better, and benefitting more people.

With a continued commitment to NIH funding, I think we will be able to do that.

We thank you for your past and for the committee's future support.

Senator CHILES. Thank you for your testimony.

Mr. SAMUEL. Thank you.

[The statements follow:]

STATEMENT OF FRANK E. SAMUEL, JR.

My name is Frank E. Samuel Jr. and I am President of the Health Industry Manufacturers Association. Our members manufacture medical devices, diagnostic products, and health information systems. Our companies' products represent approximately 90% of domestic sales. Over three-fourths are small businesses whose annual sales are under 20 million dollars. We are an entrepreneurial, innovative industry responsible for manufacturing products which are changing the art and science of health care both in this country and around the world practically on a daily basis.

I am appearing before you today in support of a funding level of 8.2 billion dollars for the National Institutes of Health (NIH), an increase of approximately eight (8) per cent over current services. This is the level recommended by the Ad Hoc Group for Medical Research Funding, and is consistent with their five year plan.

The medical technology industry exemplifies the peculiar American genius — the genius of the individual inventor and gadgeteer who finds a way to make an idea work and creates a practical product that dramatically affects the lives of people and changes how they live forever. We are the "make it work — make it better" people, the builders. But the builders must start with a good foundation. We build on the work of others — the scientists involved in basic research, as well as those active in many applied scientific disciplines.

In a way, I am here today to acknowledge a debt — a debt to NIH and the scientific research it sponsors. Hundreds, perhaps thousands, of medical devices and diagnostic products, that are creating miracles in diagnosing and curing disease, substituting for invasive surgery and eliminating needless suffering, extending life, and more importantly, vastly improving the quality of life, were developed as a direct result of original research at or sponsored by NIH. Let me give you just a few examples.

There are new diagnostic tests for cholesterol, drugs of abuse, heart attack risk and AIDS that are currently helping doctors diagnose potentially lethal health problems quickly and accurately. The basic research was done at NIH.

There are new specific receptors or sensing devices for insulin levels that are being matched with implantable pumps that are able to accurately sense the level of glucose in a diabetic and provide the proper dosage at the moment it is needed. This technology can alleviate the need for daily injections, making life for the diabetic freer and more normal. It also provides a more accurate and targeted delivery of insulin.

The technique of developing specific cells which will only match up or mate with each other and produce a specific protein in large quantities was first developed at NIH. This basic engineering of the antibody molecule is now in use with diagnostic procedures that can enable a physician to see cancerous growth with incredible accuracy and detail. By use of this technology, therapeutic drugs can be targeted directly to the cancerous growth, so that the malignant cells can be killed, but healthy body tissue will remain unaffected by the strong and potentially dangerous therapeutic agents. This makes the treatment for cancer patients much less agonizing and disfiguring.

There is a program underway now at NIH that exemplifies the growing partnership between NIH research and industry. Scientists are growing special kinds of cells in tissue cultures provided by our member companies. These special cells can be put into the bodies of cancer patients and will actually attack and kill the malignant cells. The potential for this kind of research in treating one of life's most dread diseases is incalculable.

These important developments have been accomplished by the transfer of basic research findings at NIH to manufacturers who have the applied science capability. This is not to say that our industry does not invest in research on its own. Our companies invest in research and development at over three times the national average. But as I mentioned earlier, most of our members are small companies which simply do not have the resources to conduct basic research. Even larger companies cannot afford the enormous investments that are needed today to conduct fundamental research.

What we can do and do very well is make sure that the basic scientific discoveries are turned into products that are used to better the health and well-being of the American people -- and people around the world. HIMA member companies are particularly good at applied research and adapting findings from other fields of endeavor to the medical field.

The Small Business Innovation Research (SBIR) program at NIH has been particularly successful at helping small businesses pursue and develop promising ideas. Over 3,000 small companies have submitted grant applications or contract proposals through the SBIR programs of NIH and the Public Health Service, and over 500 of them have been successful in competing for grants. Two current commercial products which are now available as a result of this grant program are a laser that removes port wine stains, and a swallowable pill electrode that can be used in an emergency or temporary procedure for cardiac pacing.

NIH is the premier medical research facility in the world. It is a national asset that needs to be sustained and allowed to continue to grow to fulfill its potential. Basic research is not a faucet that can be turned on and off, or the flow regulated from a trickle to full force by the vagaries of Administration requests or shifting priorities. It requires a sustained commitment to keep the best minds working in appropriate facilities with proper equipment. It requires a sustained commitment to provide the training and support mechanisms to keep a truly excellent research program productive.

As an industry, we have benefited from NIH research. More importantly, the American people have benefited from the development of products which have become commonplace in today's practice of medicine, developments considered miracles just a few years ago. These miracles are happening more and more rapidly as the knowledge base grows. And that knowledge base must be supported.

The budget deficit is a serious problem and we are well aware that a request for an 8 per cent increase over current services may seem out of kilter with present realities. But we wish to leave you with the message that NIH basic research is a vital investment in the health of the American people. We are proud to play our part in bringing the fruits of that effort to our nation and the world.

Thank you for giving me this opportunity to testify before your subcommittee in behalf of NIH funding.

STATEMENT OF DR. HELEN M. RANNEY, PROFESSOR OF MEDICINE, UNIVERSITY OF CALIFORNIA AT SAN DIEGO

Mr. Chairman and distinguished members of the Subcommittee, thank you for the opportunity to appear before you today to ask for your assistance in addressing the critical problems of our research infrastructure. I am Dr. Helen Ranney, Professor of Medicine, University of California, San Diego, School of Medicine and Distinguished Physician, Veterans Administration Medical Center, San Diego.

Before I begin my oral testimony, I would like to request that my written statement be placed in the record.

Lewis Thomas, a respected statesman of American medicine has pointed to the National Institutes of Health as an example of things that government can do beautifully. He has also eloquently expounded the position of medicine as "the youngest science" in which the major advances have been made at an ever accelerating rate in the years since World War II. Private philanthropy, state governments and the Federal government together have built, following World War II, a structure and system that have given to the world unparalelled advances in knowledge of human health and disease. The early days of the modern NIH* with its intramural and extramural programs and the national biomedical research effort of which it is the principal component coincided with the discovery of newer antibiotics (early sulfonomides and penicillin were extensively used during World War II) and the remarkable decline in death rates from infectious diseases. Discoveries made in the 1930's and 1940's concerning the chemical constituents of cells provided the basis for greater understanding of the biology of cancer and greater understanding of the heterogeneous nature of heart disease. Just as the progress in science of the 1930's and 1940's provided the basis for the recent era of historic accomplishments, so do the results of research in the last three or four decades prepare us for continuing quantum advances in medicine.

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* While the NIH was founded on Staten Island in 1887, the "modern" NIH began largely after World War II.

But now we find that the infrastructure upon which such progress depends has some serious defects reflecting both the lack of preventive maintenance and the failure of expansion in facilities for research to accompany the growth in knowledge of biology.

Many of the laboratories at universities in the 1960's and 1970's were built with Federal dollars that were provided to medical schools for expanding the size of medical school classes. Other special research buildings were erected in the 1970's funded under the National Cancer Act of 1971.

Many naysayers have pointed out that the War on Cancer remains to be won, a statement with which most of us would agree. At the time when the campaign against cancer was planned, many of the planners did not recognize that we simply did not have the essential knowledge of normal biology or of cancer biology necessary to plan or to wage the war. Other scientists did recognize the problem, and in the interveneing years, cancer research has contributed enormously to our knowledge of normal and abnormal cellular and molecular biology, virology and immunology. Treatment, often experimental, has brought new knowledge of the effects of drugs on many different cellular components. Some important advances in the neurosciences, and in genetics have come from information derived from cancer research.

Perhaps we became overconfident about our ability to handle infectious disease. After all, within a very short time we had conquered many of the previous killers of populations -- from the Plague to the pneumococcus and malaria. Furthermore, new or hitherto unrecognized diseases like Legionnaire's Disease, Toxic Shock and Lyme Disease were recognized and their etiology established, frequently rather speedily. Also most of these new infectious diseases were susceptible to treatment by antibiotics.

Then in 1981 came AIDS. Described in groups of homosexual men from New York and Los Angeles, this mysterious disorder has cast a shadow over America, Western Europe and Africa. The shadow is derived from the current inevitably fatal outcome of AIDS. Yet, in five or six years following the description of the disorder, its etiology and some aspects of its pathogenesis had been clarified. AIDS is caused by a virus which destroys a subset of lymphocytes, a necessary part of the human immune system. With severely impaired immune systems, the victims of AIDS are susceptible, and usually die of, intercurrent infections which would be of little moment to individuals with normal immune systems.

This new disease has served to remind us of the human condition and the organisms in the environment. The threat of new and serious diseases were not anticipated when the deaths from AIDS began to occur. Striking as it does mostly younger people -- homosexual or bisexual males, intravenous drug users, children who have been infected before birth, recipients of contaminated blood transfusions -- the direct medical costs of AIDS in 1991 have been estimated at $8.5 billion with indirect costs (lost productuvity) six times that amount.

The need for additional research in AIDS is clear. Yet, the fatal nature of the illness and the fact that it has been transmitted in laboratories makes it mandatory that research personnel in AIDS programs whether they be senior scientists or laboratory aides, have adequate protection from infection with the virus. This means that the virus cannot be handled in overcrowded laboratories which lack appropriate containment facilities. Almost no research institutions have adequate laboratory space available for AIDS research unless some other research program is abandoned. We cannot give up research in heart disease or cancer or leukemia or renal diseases to make space avilable for research in AIDS when we can predict confidently that advances in these fields will also continue to be made at a rapid rate.

The need for research in AIDS has focused attention on the overcrowded, often inadequately maintained facilities for biomedical research, a problem that has not been addressed for a number of years. However, we cannot afford to make the mistake of advancing our knowledge in AIDS at the price of ignoring research initiatives in other areas. There is no question that we are just at the edge of our understanding about cancer and other diseases like heart disease. The degenerative diseases of an aging population, including Alzheimer's disease and other dementias are beginning to be better understood. In these, and in other areas of medicine, further basic research that we cannot plan or anticipate will bring new insights and perhaps in the future new treatments. The kind of basic research in immunology and in virology needed for AIDS research may yield information important in Alzheimer's disease or cancer. This is, of course, reminiscent of the role of basic research in cancer in the delineation of our current knowledge of AIDS. It is hoped that the present NIH and biomedical research community have the same kind of good judgement about basic research in AIDS as did their predecessors in recognizing the role of basic research in the War on Cancer.

Several recent studies have documented the need for modernization of the nation's research infrastructure. The White House Panel on the Health of U.S. Colleges and Universities, also known as the Packard Commission, as well as the National Science Foundation have each recommended in their reports that the research infrastructure for facilities and instrumentation needs support. The White House Report estimates that it would cost about $10 billion over the next 10 years to improve the facilities, construction and infrastructure problems in academic institutions.

The last NIH appropriation for research facilities was in 1968. The National Cancer Act, passed in 1971, provided research facilities for cancer. Those investments have stood us well as our laboratories have made greater advances against disease and disability in the last 20 years than they had since the turn of the century. However, increased health and safety requirements, increased need for environmental protection, and new regulations for animal research facilities necessitate improved research facilities.

Decline in Federal support for academic research facilities has dropped 85%, when adjusted for inflation, during the past two decades. In 1963, Federal support for research facilities was $325 million. In 1984, Federal support was $49.5 million.

We support the Ad Hoc Coalition for Biomedical Research's recommendation of $250 million for support of biomedical research facilities in FY 1989. These funds are necessary if we are to continue to respond in a timely fashion to the growing challenges and information explosion we are experiencing in biomedical research. In addition, I urge the Congress not to meet the needs of our decaying infrastructure by "robbing Peter to pay Paul." Redirecting resources from basic and applied research initiatives in this fiscal year and in the years ahead would cripple many research programs and, in the long run, decrease our ability to effectively meet the challenges which lie ahead.

Another infrastructure resource which needs addressed is that of training. The National Academy of Sciences has recently reported a growing shortage of trained researchers. Maintaining a supply of trained scientists is a long term investment. It is not possible to produce an adequate supply of researchers on short notice. The investment takes a period of 8 to 10 years post-baccalaureate -- to say nothing of interesting young junior high and high school students in careers in science. Attracting the best and brightest minds of this nation and adequately supporting them in their educational pursuit through the PhD degree and post-doctural training must become a priority of this nation if we are to maintain a preeminence in this field.

We support the recommendations of the Ad Hoc Coalition which calls for approximately 11,350 trainees as well as their recommendations to increase the pre- and post-doctoral stipends.

Mr. Chairman, members of the Subcommittee, this concludes my formal testimony and I will be happy to answer any questions that you may have for me. I hope that in your Committe deliberations on research funding and the choices that you will have to make given your responsiblity to the fiscal problems of this nation, that you will begin to address the long term investments of our infrastructure.

STATEMENTS OF:

JEAN F. McGUIRE, EXECUTIVE DIRECTOR, AIDS ACTION COUNCIL

JEFFREY LEVI, EXECUTIVE DIRECTOR, NATIONAL GAY AND LESBIAN TASK FORCE

Senator CHILES. Now we will hear from Jean McGuire, executive director of the AIDS Action Council.

Ms. McGUIRE. Good morning, Mr. Chairman.

I'm going to ask Mr. Jeff Levi to join me at the table, since we will both be speaking from a document that we are submitting for the record, which has been prepared on behalf of the member organizations of a coalition called National Organizations Responding to AIDS.

Mr. LEVI. Good morning, Mr. Chairman.

I am Jeff Levi. I am executive director of the National Gay and Lesbian Task Force, the Nation's oldest gay and lesbian advocacy organization.

It is always a pleasure to appear before you. Your commitment to full funding for the AIDS effort throughout a period of retrenchment in the budget process is deeply appreciated by the tens of thousands who have been affected by this crisis.

AIDS is a public health crisis in the broadest sense, posing difficult challenges in research, prevention, and health care delivery. It is in the area of access to care that some of the most severe problems threaten to arise in the next year. It is this area that I hope this committee will direct the Public Health Service to address more directly in 1989.

The administration's $1.3 billion request for AIDS in fiscal year 1989 is a welcome increase compared to requests in previous years. We are deeply concerned that this level is insufficient to meet the growing threat AIDS poses to our health care system. Indeed, our organization has joined with the National Organizations Responding to AIDS, or NORA, who have put together a more detailed analysis that justifies just over $2 billion in funding in fiscal year 1989.

In the brief time that I have this morning, I want to quickly outline some of the key points of that analysis, which I would like to submit for the record.

One of the most important issues at all the agencies—at the NIH in particular—is that of staffing.

We appreciate the Senate's willingness to mandate FTE levels in the past and hope the Senate will prevail on this issue this year. As Dr. Fauci recently testified, the ability of NIH to put into clinical trials promising therapies for AIDS has been hampered by insufficient FTE's in the NIH AIDS program. This is a tragic and intolerable situation. In fact, without guarantees of staffing, allocating more money to AIDS is not very meaningful.

We are concerned that this problem persists at agencies other than NIH as well, including the CDC, for which the administration has requested a $95 million increase, but only 16 more FTE's. All 16 FTE's would be assigned to the $25 million seroprevalence study, leaving $70 million in additional funding for CDC programs, but no new staff at an agency that has a long history of diverting staff from other important health programs.

Thus, if only one alteration were made in the President's budget, we believe the most significant one would be one that mandated the availability of sufficient FTE's to make the AIDS program work.

There are many other areas that the NORA document addresses, including the need to target education and prevention programs through community based organizations. Individuals at risk to AIDS are not likely to hear a message about sexual practices or drug use that comes from the Federal or State government. Organizations with links to those individuals will be much more effective.

Similarly, as this disease continues, tragically, to disproportionately affect minorities, we must do a better job of targeting education moneys to groups working with minorities.

You will hear in more detail from my colleague about the need for this year's budget to address the issue of how our Nation's public health system will provide adequate care for the hundreds of thousands of people who will be getting AIDS in the years ahead. I simply want to emphasize the importance of Congress adding health care to its already strong commitment to research and prevention in the AIDS crisis.

PREPARED STATEMENT

Again, please accept the thanks of my organization and our constituents for your longstanding support for a comprehensive national AIDS policy. We look forward to working with you this year and regret that you won't be here next year.

[The statement follows:]

STATEMENT OF JEFFREY LEVI

Mr. Chairman, it is always a pleasure to appear before you and your colleagues. Your commitment to full funding for the AIDS effort throughout a period of retrenchment in the budget process is deeply appreciated by the tens of thousands who have been affected by this crisis. We know we can count on your continuing responsiveness to this pressing health crisis. AIDS is a public health crisis in the broadest sense--posing difficult challenges in research, prevention, and health care delivery. It is in the area of access to care that some of the most severe problems threaten to arise in the next year. It is an area that I hope this committee will direct the Public Health Service to address more directly in 1989.

The Administration's $1.3 billion request for AIDS in FY 1989 is a welcome increase compared to requests in previous years. But we are deeply concerned that this level is insufficient to meet the growing threat AIDS poses to our health care system. Indeed, our organization feels $2 billion in spending could easily be justified--an amount bringing us to the National Academy of Sciences' target for spending by 1991. But even that may not be sufficient. The presidential commission has been coming forward with sound advice regarding how we must expand and improve our AIDS efforts. I urge the committee to be open to increases that may go beyond the budget resolution to meet the critical needs the commission and others are identifying.

Administrative and Management Issues

There are several administrative issues posed by the Administration's request that we hope the committee will address to assure a more effective AIDS program. First, we urge rejection of the Administration's request that fiscal 1989 funds "remain available until expended." There is no excuse for not spending the full amount Congress appropriates given the magnitude of the need. The Administration should not be permitted to appear to be doing more than it actually is.

Second, we urge continued rejection of a single AIDS account at PHS. Experience shows this does not improve coordination, but rather creates another level of bureaucracy that delays availability of funds.

Third, we question the value of a $15 million contingency fund. We fear this will become an excuse not to spend money. Similarly, we hope you will deny PHS blanket authority to reprogram up to 3% of the non-AIDS PHS budget to AIDS. We are deeply concerned by any attempt to take funds away from non-AIDS programs. Congress has always been responsive to the changing needs of the PHS throughout this crisis; there is no need to alter the existing system at this time.

The committee must also address some serious management issues associated with the expenditure of appropriated funds. Just as the Administration should not be permitted to have blanket authority to stretch expenditures over an indefinite period of time, so too, the committee must make certain, through statutory language, that allocated funds are spent as expeditiously and as effectively as possible. Rapid turnaround times should be mandated for review of research and prevention grant proposals.

There is an additional management problem relating to allocation of FTEs for AIDS programs. Without the staff to support the programs, allocating more money to them is almost meaningless. There has been a consistent logjam at the OMB in getting approval for additional staff for the AIDS program--staff not taken at the expense of other health projects. Dr. Fauci's recent testimony before a House subcommittee about the lack of staff holding up trials of promising AIDS therapies makes compelling the need to mandate in legislation the staffing levels for PHS AIDS programs.

Prevention

Absent a vaccine for AIDS, prevention is our best and only hope for halting the spread of this disease. As reflected in the Administration's budget, prevention programs are divided between HIV testing and public education efforts. We believe that testing is too large a focus of the AIDS prevention effort. The most successful prevention programs have been among gay men--most of whom have adopted prevention strategies without testing. Further, while the Administration requests close to $100 million for an HIV testing program, it has not requested sufficient funds for the intensive counseling that is required to make a testing program successful. Testing is only as good as the counseling about prevention and behavior change that accompanies it. Agencies providing counseling services are overwhelmed and often diverting staff and resources from other vital counseling activities; another $100 million could easily be spent on counseling services alone if we were to adequately meet the need.

Funding and training is required to provide the long-term counseling many HIV positive individuals need. Current counseling programs provide only for the short-term assistance of HIV positive individuals. The long-term impact of this status is significant and extended counseling is needed to reinforce the required behavior changes and cope with the psychological problems that can result from learning one is HIV positive.

AIDS education poses special challenges given the diversity of the populations affected by the disease. AIDS prevention programs have been inconsistent in reaching various populations. Ignorance about basic transmission and prevention issues persists in the general public. Minority groups have been particularly neglected, both in gay and nongay populations.

It is increasingly clear that a national education/prevention program cannot reach all populations through centralized efforts at the CDC or any other federal agency. Different audiences respond to different messages; often the very audiences we are trying to reach will respond negatively to a message delivered by a government entity. To more effectively accomplish AIDS prevention and education, we should move to a program that stresses at the national level a general education message that makes all Americans feel AIDS is their problem: one that could affect them directly as a persons potentially at risk and/or one that deserves their compassionate concern. But the essential corollary to this is a willingness to **provide money to community based organizations who can indeed reach individuals who engage in high risk behavior.**

The need for expanded prevention is also evidenced by the general increase in sexually transmitted diseases (STDs) among heterosexuals. Mounting evidence that other STDs may be a cofactor in the development of AIDS and the fact that AIDS and STDs are contracted by the same behaviors make clear the need to link AIDS control and STD control and prevention. STD prevention programs should be doubled from the current $65 million level.

Family planning clinics, maternal and child health centers, and similar sites are also important vehicles for reaching heterosexuals at risk. Funding should be provided for stepped-up AIDS-specific efforts in these settings.

Drug Abuse

The greatest public concern recently has been with the growing threat of AIDS among IV drug users. **The most effective way to stop the spread of AIDS through sharing of IV drug needles is to stop IV drug abuse.** This can only be accomplished if adequate treatment facilities are available for those wishing to overcome their addiction and street outreach efforts are made to bring individuals into treatment. One of the tragedies of AIDS and the drug crisis in America today is the long waiting list for treatment programs. Significant increases in funds should be provided to assure that all those seeking treatment will have it available to them.

Health Care

With a predicted 270,000 cases of AIDS by the end of 1991—as compared to approximately 60,000 today—**delivery of health care will be the most compelling issue in the next few years.** How we prepare for this challenge will determine whether we avoid having a health care system that is overwhelmed and cities that are bankrupted by this burden.

We still have a long way to go in developing alternative models for addressing the health care needs of persons with AIDS, ARC and HIV infection--particularly models that reduce hospitalization and care costs.

The AIDS caseload is expected to increase dramatically over the next several years in all jurisdictions, not just the current high-incidence states. Nonetheless, few are preparing for this increased demand on their health care delivery systems. **Planning in each state must be encouraged by the federal government.**

In addition, the committee should explore **impact aid for heavily affected cities that are providing, from their own resources, high quality care to persons with AIDS** to assure that these cities will not become bankrupted by the added burden of an increasing case load. AIDS is a national problem; the burden of cost of care should not be borne by a handful of communities alone.

Research

The President's budget must be carefully examined to determine if sufficient funds are provided for **expanding the number of individuals able to participate in clinical trials of AIDS drugs.** We are concerned that the administration has underestimated the per patient cost of these trials and not factored in the additional cost of outreach to population groups affected by AIDS who have been difficult to recruit into clinical trials but who offer important demographic contributions to the trial process. Thus drug trial centers may not be able to enroll as many individuals--slowing down the process of identifying effective therapies. An estimated $20 million in additional funds should be appropriated to make up this deficiency.

The NIAID needs an additional $25 million for the establishment of AIDS Research Centers to provide multidisciplinary opportunities for collaborative approaches to research on AIDS. Similar to the approach to cancer research, these centers would allow integration of basic and clinical research, recruitment and training of physician-scientists, dissemination of research findings to the scientific and lay communities, and technology transfer to medical care providers.

With the prospects for development of a vaccine or a real cure for AIDS some years away, primary prevention of this epidemic requires that people change their behaviors. We are a long way from fully understanding how to achieve this kind of change. Psychosocial research is critical to better accomplishing this end. We are concerned that the ADAMHA budget request does not provide sufficient funds for psychosocial research in absolute terms and in proportion to the funding provided for neuroscience at ADAMHA.

Research on AIDS will be an important scientific objective for some time. We need to expand the number of research training slots available at NIH to prepare a new generation of researchers for work on AIDS. We support the NIH proposal for 269 full-time AIDS training positions. We also must make sure that both the PHS and other health care research and care facilities are able to recruit physicians and nurses to do AIDS work. Given the lower salaries that are generally associated with government research and public hospitals, alternative incentives should be considered, such as education loan forgiveness for those entering AIDS research and care.

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One final, important comment: In asking for additional funding for AIDS, we are quite cognizant of the other demands that are placed on the health budget. We must address the dramatic needs posed by AIDS without sacrificing continued progress in other important health care areas. In fact, such approaches in the past--as when prevention programs for sexually transmitted diseases were diverted to AIDS--have only served to compound the AIDS and general public health problem further down the road. We know you share our view that progress on AIDS contributes to progress in other health areas--and should not be at their expense.

Thank you again, Mr. Chairman, for your leadership in our nation's battle against AIDS.

NATIONAL ORGANIZATIONS RESPONDING TO AIDS (NORA)

NATIONAL INSTITUTES OF HEALTH

FY 89 NORA recommendation: $747,238,000
FY 89 Administration request: $587,630,000
FY 88: $467,146,000

We support the increases requested by the Administration for FY 89 as well as some additional initiatives. We also support a continued commitment to basic research -- research that has provided the base from which so much progress on AIDS was possible.

The staffing problem at NIH is particularly critical. As the NIH AIDS coordinator has testified before a House subcommittee, insufficient FTEs has resulted in inexcusable delays in putting into trial promising therapies for AIDS. Without guarantees of staffing, allocating more money to AIDS is meaningless. We recognize the reluctance of the Congress to legislate in this area, but it is essential for effective use of appropriated funds. We therefore urge that the FTE levels for NIH be included in this year's appropriations bill.

We endorse the recommendations of the Presidential Commission on the HIV Epidemic in the research area. We support their recommendation that basic research grants in virology, immunology, and other HIV-related areas be increased by 15 percent, at a cost of $90 million. Included with the money should be direction that NIH pursue with greater vigor the issue of cofactors -- from a scientific and epidemiologic point of view.

We support the NIH's and Presidential Commission's proposals that research efforts include community-based clinicians in clinical trials. Patterned after the New York City Community Research Initiative, such programs expand the number of people participating in trials while keeping infrastructure costs down.

Increasing funding is only part of the need in the grant area. The Congress must make certain that appropriated funds are spent as expeditiously as possible. We therefore urge that the Congress direct the NIH to make decisions on research grant proposals and applications within six months.

The President's budget calls for 70 additional FTEs for NIH's AIDS work. We support the Presidential commission's recommendation that FTEs be increased by 120 for basic research and 70 for clinical trials -- at a net increase in the President's budget of $7.2 million.

The involvement of community-based physicians in the clinical trial process is increasingly recognized as key to successful and demographically diverse trials. We therefore endorse the Commission's recommendation that $5 million be specifically appropriated for this approach.

In addition, we endorse the unmet request of the NIAID in its professional judgment budget for the creation of AIDS Research Centers, at a cost of $25 million, to provide multidisciplinary opportunities for collaborative approaches to research on AIDS. Similar to the approach to cancer research, these centers would allow integration of basic and clinical research, recruitment and training of physician-scientists, dissemination of research findings to the scientific and lay communities, and technology transfer to medical care providers.

An additional $20 million is needed to expand the number of patients in clinical trials of AIDS drugs, according to the NIAID professional judgment budget. We are concerned that the administration budget underestimates the per patient cost of these trials. We would also urge that in funding these trials the Congress direct the NIH to assure that the demographic characteristics of those participating in the trials reflect the demographics of the population affected by AIDS. Clinical trials are the only hope we have to offer persons with AIDS; all persons with AIDS -- irrespective of sex, race, or risk factor -- should have equal access to that hope.

We are concerned that the Division of Research Resources is being cut in the President's budget by $12,408,000. We urge that this cut be restored, since funding through DRR's General Clinical Research Center Program supports the institutions doing AIDS research. For the rest of the research money to be effective, we must make sure that the institutions contracted with have sufficient space and staffing.

We endorse the Administration's request for additional research training slots. Nothing could be more important to our research efforts on AIDS than assuring a continuing stream of physicians and scientists trained in this area as our needs expand.

Access to dental care by person with AIDS is an increasingly difficult problem. We urge, therefore, that the Congress direct the National Institute of Dental Research to condition any grants to institutions with dental clinics on a guarantee of access to those clinics for persons with AIDS.

CENTERS FOR DISEASE CONTROL

NORA FY 89 recommendation: $697,019,000
FY 89 Administration request: $400,719,000
FY 88: $384,942,000

Management

The PHS has circulated a proposal for converting the PHS/CDC prevention and surveillance activities into a block grant. It is possible that elements of this proposal will be implemented administratively. We urge the Congress to direct the CDC not to undertake such a move. Unless clear distinctions are made among prevention, surveillance, and testing activities, one or more of these areas may be compromised. The record of enforcement or evaluation of spending on block grants by the federal government is weak; keeping these programs separate offers more hope that the work they are intended to accomplish will indeed be performed.

We are also concerned that the Administration's budget does not provide sufficient staff for the CDC's AIDS activities, which could result in borrowing staff from other important programs and/or could result in inadequate monetary or administrative support for the CDC's AIDS-related activities. The Administration's budget calls for only 16 new FTEs despite a spending increase of $95 million. Most, if not all, of those FTEs would go to the $25 million seroprevalence study. More staff will be needed to support the other activities of the agency.

Surveillance/Epidemiology

Most of the administration's increase covers the cost of the seroprevalence survey to determine the level of infection in the United States with HIV. We recognize the Administration's commitment to this study, which will cost an additional $25,480,000 over 1988 -- or most of the CDC's request for increased funding in the surveillance area. We also support increased funding for the CDC's proposed study of high risk behaviors ($5,154,000) and an additional $1 million to support international surveillance. However, we also recognize that there are additional areas that require attention. These other areas include:

Increased funding for state and local surveillance of AIDS cases. The CDC's draft of block grant legislation proposed $10.3 million; we endorse that amount, even though it is not specified in the CDC's budget justifications submitted to the Congress, but object to the block grant approach.

The links between increased tuberculosis and AIDS require closer monitoring. The CDC proposes to spend $1.9 million on this area in 1990; we urge that this program be implemented in 1989.

We support the CDC's request for expanded epidemiologic studies. Understanding the natural history of HIV infection in various populations may well provide clues to better understanding of prevention and treatment of the infection.

Information/Education

Absent a vaccine for AIDS, prevention is our best and only hope for halting the spread of this disease. As reflected in the Administration's budget, prevention programs are divided between HIV testing and public education efforts. We believe that testing is too large a focus of the AIDS prevention efforts and that sufficient funds must be allocated for the counseling activities that make testing effective. We also believe that insufficient resources are allotted to community-based organizations that are doing the bulk of the education/prevention work on AIDS--the real work that will bring this epidemic to a halt.

We endorse the CDC's requested increases in this area, but urge the following additions:

We urge an additional $100 million beyond the $102,400,000 in the CDC's budget for expanded HIV testing and counseling. This reflects two goals: to assure that additional HIV counseling and testing at STD, women's health, family planning, and drug abuse clinics be funded and staffed with new money -- rather than diverted from other important programs; and to assure that full counseling accompanies the testing programs. Because testing is often added without sufficient resources for counseling, the testing performed at these sites is either ineffective or at the expense of other health promotion activities. Even at $200 million, counseling and testing would be funded at half the level the House Health Subcommittee is considering for the next fiscal year. (At $100 per person, a very low estimate, for testing and counseling, this would fund only 2 million individuals -- less than one percent of the American population, and approximately the number of people thought to be infected with HIV.)

It is increasingly clear that a national education/prevention program cannot reach all populations through centralized efforts at the CDC or any other federal agency. Different audiences respond to different messages; often the very audiences we are trying to reach will respond negatively to a message delivered by a government entity. To more effectively accomplish AIDS prevention and education, we should move to a program that stresses at the national level a general education message that makes all Americans feel AIDS is their problem: one that could affect them directly as a persons potentially at risk and/or one that deserves their compassionate concern. Such an approach would accomplish two ends: it would help undermine discriminatory attitudes toward those affected by AIDS and it would make those at risk more susceptible to a targeted message that can never be specific enough in a general campaign. But the essential corollary to this is a willingness to provide money to community based organizations who can indeed reach individuals who engage in high risk behavior.

We therefore urge an additional $100 million be appropriated for targeted education programs for those engaging in high-risk behavior, as a supplement to funds passed through the states. These funds should be directed at the various populations -- gay/bisexual men, intravenous drug users, those with learning disabilities, people with mental illness, etc. -- who might require specially tailored messages. These funds should go directly to community-based organizations and national groups working with populations engaging in high-risk behavior, with at least 60 percent going to those working with minority groups -- reflecting the demographics of the population affected by AIDS. [This is in addition to the $72 million the CDC has requested for targeted education and the $41 million for general information/education. Only $25 million of the targeted money in the CDC request is for minorities, the added dollars would bring funding for minorities to $85 million. Only $417,000 of the CDC request is specifically targeted for community-based organizations, even though these are the groups with the best ability to reach those most at risk for AIDS.]

The need for expanded prevention is also evidenced by the general increase in sexually transmitted diseases (STDs) among heterosexuals. Mounting evidence that other STDs may be a cofactor in the development of AIDS and the fact that AIDS and STDs are contracted by the same behaviors make clear the need to link AIDS control and STD control and prevention. STD prevention programs should be doubled from the current $65 million level. We must move the bureaucracy from seeing STD prevention programs as a resource from which money and staff can be diverted to AIDS to seeing STD prevention as a critical part of AIDS prevention efforts.

Only $2.7 million is allotted for the National AIDS Hotline for FY 89. Since it is functioning at approximately $6.5 million in the current fiscal year, it should be funded at a minimum of $9 million in 1989, to allow for increased usage as public awareness of AIDS increases.

All federally funded testing programs should be required to participate in the CDC's laboratory proficiency program. There are reports of higher false positive rates in some laboratories and inconsistencies in interpretation of tests across the country. The significance of these tests is such that we must assure that they are accurately performed in accordance with a standard set and verified by the CDC. The CDC budget plans for $2.8 million in this area in 1990; there is no justification for delaying this program and we urge appropriation of $2.8 million above the Administration's request for this purpose.

Insufficient attention is devoted to coordinating and evaluating the various education and prevention efforts that occur within a state. Special grants should be given to the state and local agencies, at the level of $10 million, to assure that public and private prevention work is coordinated and that scientifically sound evaluation is performed on all prevention activities occurring in a community.

HEALTH RESOURCES & SERVICES ADMINISTRATION

FY 89 NORA recommendation: $304,008,000
FY 89 Administration request: $40,016,000
FY 88: $36,956,000

With a predicted 270,000 cases of AIDS by the end of 1991, as compared to about 60,000 today, delivery of health care will be the most compelling issue in the next few years. How we prepare for this challenge will determine whether we end up with a health care system that is overwhelmed by AIDS or one that faces this new challenge competently and compassionately. We, therefore, endorse increases in funding levels of Administration-proposed programs, as well as several initiatives in this area.

We support the HRSA request, with a number of significant increases that reflect the greater priority we believe the health care area should be given.

AIDS Education and Training Centers
FY 88: $11,106,000
FY 89 Administration request: $12,882,000
NORA recommendation: same

This increase allows for continuation of about 10 existing ETCs and creation of five new ones.

AIDS Services Demonstration Centers
FY 88: $14,361,000
FY 89 Administration request: $10,756,000
NORA FY 89 recommendation: $15,000,000

The Administration request suggests that it will be possible to fund more demonstration centers, creating models of community-based AIDS care, with less money (moving from 19-22 grants to 28-31 grants). Given the critical need to expand the number of communities establishing models for care, we believe these centers should receive adequate funds for expansion, beyond the projected 30 cities.

Pediatric AIDS Service Demonstration Projects
FY 88: $4,787,000
FY 89 Administration request: $5,000,000
NORA FY 89 recommendation: $10,000,000

Pediatric AIDS is a growing problem in a sector of the population least able to afford quality care. The number of pediatric cases is rising exponentially--far beyond the general rate of increase. The Administration is requesting essentially level funding, but plans to double the number of demonstration centers. We support the doubling of demonstration projects; however, we believe funding should increase accordingly.

AIDS Curriculum Development
FY 88: --
FY 89 Administration request: $5,126,000
NORA FY 89 recommendation: same

It is extremely important to increase the provider training for AIDS throughout the country. Development of model curricula is a vital step in this process.

AIDS Planning Grants to States
NORA recommendation: $10 million

There is expected to be a dramatic increase in the AIDS caseload over the next three years -- as well as a geographic shift from the current centers of the epidemic. Few of the low and middle incidence states are planning for this increase, and the federal government should be providing the incentive through planning grants.

Special Assistance for AIDS Care
NORA recommendation: $100 million

Cities and states most heavily affected by AIDS have been providing, from their own resources, funds to assure quality care for persons with AIDS. As the problem grows, maintaining these services threatens to affect the fiscal viability of some of these communities -- forcing them to choose between continuing vital services to persons with AIDS and fiscal responsibility. While large numbers of AIDS cases are currently affecting only a handful of communities, AIDS should be seen as a national problem; the burden of the cost of care should not be borne by those communities alone. Special assistance to those communities, distributed on the basis of incidence of AIDS in those communities, would begin to redistribute that burden. (Assuming 35,000 living cases in FY 89, this would come to a subsidy of less than $3,000 per patient, a fraction of the actual cost of care.) This approach is designed to meet an immediate crisis faced by a number of communities. It does not reflect a solution to the long-term health financing problems posed by AIDS.

Health Care Professionals Incentive Program
NORA recommendation: $50 million

Research into AIDS and providing care for persons with AIDS will be a long-standing need. There is increasing evidence that shortages of health care professionals will exist in the AIDS research and care areas. One method for increasing the number of people willing to train for and care or do research in this area would be to provide education loan forgiveness for those willing to commit to a set period of time in the AIDS field. This should be an incentive for newly trained personnel to enter the field and for those already working in AIDS to remain. (The average cost of a nurse's private education is about $40,000; for a physician, approximately $100,000. If this fund were divided evenly between nurses and physicians, it could cover one-third of the training costs of about 2,000 nurses and 700 doctors.)

AIDS Training and Counseling: Health Personnel in Federally Supported Health Facilities
FY 88: --
FY 89: $6,252,000
NORA recommendation: $56,000,000

The Administration request is designed to train staff in HIV education and counseling at federally funded health facilities such as Community Health Centers. However, in addition to the training, additional funds need to be provided to help these centers recover the actual cost of counseling about HIV, or there will be an overall diminution of services to the clients of these facilities.

Legal and Advocacy Services Centers
NORA recommendation: $10 million

The problem of discrimination against persons with AIDS or HIV infection is a growing one. That discrimination undermines the effectiveness of the public health establishment's ability to reach out to those at risk to this disease. While some federal and state protections exist, persons who are victims of discrimination need access to legal and advocacy services. These funds would allow the creation of demonstration programs at selected sites around the country to serve as models for the future.

Regional AIDS Treatment Center Demonstration Project
NORA recommendation: $10 million

This would allow creation of up to four region centers to evaluate the appropriateness of a regional approach to AIDS patient care, particularly in medium and low prevalence areas.

Demonstration HIV Monitoring and Treatment Centers
NORA recommendation: $25 million

This would be a demonstration program for the estimated 1.5 million people who are HIV positive but so far asymptomatic. The six centers would be designed to monitor more closely the clinical and laboratory immune functioning of these individuals, provide information and counseling on possible treatment, help meet the mental health needs of seropositive individuals, and offer prophylactic treatments as indicated. These centers may need to be linked to NIH-approved research studies of effective treatments for asymptomatic seropositives.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

FY 89 NORA recommendation: $316,562,000
FY 89 Administration request: $177,617,000
FY 88: $112,257,000

Research
While the President has proposed increases in research at ADAMHA, the level of effort proposed does not reflect the real need in the area of the social, behavioral, and neurosciences. AIDS can be controlled through behavior changes, yet research on how to change behavior has been chronically underfunded. The increased funding proposed for ADAMHA beyond the Administration's budget request is based on recommendations by the Coalition for AIDS Prevention and Education. These levels would permit:

Award of approximately 42 new and competing research project grants at Council-approved levels providing for significant additional attention to: descriptive studies of drug use, sexual patterns and other relevant behaviors; the neuropsychiatric complications attendant to HIV infection particularly among the asymptomatic seropositives; the psychosocial sequela of AIDS such as stigma, violence, bereavement and discrimination; testing of specific interventions targeted at specific groups such as black and latino gay and bisexual men, persons using drugs and alcohol during sex, homosexual adolescents, low-income and low-education individuals, and ethnic-minority women; the development of new drugs for IV drug treatment such as buprenorphine and LAAM; and, the role of substances of abuse, such as alcohol, as co-factors
Funding of a research program to develop and test the efficacy of theory-driven interventions designed to modify the behaviors and norms of entire communities. This program would borrow from the success of other community-based prevention programs recently completed and/or currently under way. Such an initiative, to be carried out over a multi-year period, would be based on the examples of the National Heart, Lung and Blood Institute's cardiovascular disease prevention program known as the Stanford Heart Disease Prevention Program or the National Cancer Institute's Community Intervention Trial to reduce the prevalence of heavy smoking currently under way in 22 communities in Canada and the United States.

Support for the expansion of the number of FTEs currently working on AIDS issues within ADAMHA without pulling existing staff out of other on-going programs. In order to continue to address the pressing AIDS issues at NIDA and NIMH, additional FTEs must be funded. This funding level would expand NIDA's program staff from 29 to 60. The situation at NIMH is particularly serious, as there are virtually no discrete staff resources for AIDS. This level of funding would allow for the addition of 40 new FTEs for NIMH.

The breakdown of funding at ADAMHA would be: NIMH -- $66.8 million (compared to the administration's request of $49.4 million); NIDA -- $128 million (compared to a request of $122 million); and NIAAA -- $8 million (compared to 6 million).

AIDS Service Delivery

We support the recommendations of CAPE regarding AIDS service delivery at ADAMHA, raising funding to $230 million (from $116.2 million). This increase would allow for attention to the mental health needs of persons affected by HIV infection and expand the role of the federal government in providing drug treatment services where they are needed.

We have become increasingly aware of the long-term mental health consequences of HIV disease. The infected asymptomatic individual is faced with the constant prospect of death. The stress of coping with an AIDS diagnosis presents a most difficult challenge. In addition, if HIV-infected individuals are to alter their most intimate behaviors we must provide on-going support for maintaining behavior change in order to sustain the remarkable gains we have already achieved. Therefore, we support funding, through NIMH, for mental health services for persons infected or affected by AIDS.

The President's Commission on the HIV Epidemic made clear the urgent need for expanded treatment for IV drug users. The Commission recommended that drug treatment be available on demand with funding at a level of $1.5 billion. We recognize that such levels of funding may not be realistic in the current fiscal year. But significant increases in funding over and above current levels for drug treatment are needed, so we can start building the infrastructure that will allow us to offer, in the future, treatment on demand.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

FY 89 NORA recommendation: $13,598,000
FY 89 Administration request: $28,598,000
FY 88: $4,308,000

In addition to seeking additional funding for the OASH, the Administration seeks additional authority in the Assistant Secretary's office regarding administration and control over the AIDS programs of the PHS.

The Administration has requested that fiscal 89 funds "remain available until expended." We oppose such a blanket authority, though we recognize that certain types of programs may not spend all funds that are obligated in a given fiscal year.

We also urge rejection of the Administration's request to merge all AIDS funding into a single account at the OASH level. Experience has shown that greater central control over funding only creates another level of bureaucracy that delays availability of funds; it does not improve coordination.

We question the value of a $15 million contingency fund and have therefore not included it in our recommendations. We fear this will become an excuse not to spend money. Similarly, we urge rejection of the request for authority to reprogram up to 3 percent of the non-AIDS PHS budget to AIDS. Congress has always been responsive to the changing needs of the PHS throughout the AIDS crisis -- often more responsive than the Administration itself. There is no need for special authorities at this time.

The level funding proposed for the Office of Minority Health, at $1.5 million, is inadequate in light of the minimal levels proposed for minority programs at the CDC. We are concerned, however, at the potential for duplication between the CDC and OMH efforts and urge that the total funding for minority programs (approximately $100 million in the NORA recommendations) include a stipulation that CDC and OMH work together in distributing the funds and implementing targeted programs.

AN ALTERNATIVE AIDS BUDGET FOR FY 1989
May 1988

PUBLIC HEALTH SERVICE AIDS FUNDING
(in millions, excluding FDA)

Agency	FY 1988	Admin. FY 89	NORA FY 89
ADAMHA	$112.257	$177.617	$316.562
CDC	304.942	400.719	697.019
HRSA	36.956	40.016	304.008
NIH	467.146	587.630	747.238
OASH	4.308	28.598	13.598
Total	$925.609	$1,234.580	$2,078.425

As of May 18, 1988, the following organizations have endorsed this document:

AIDS Action Council
American Association for Marriage and Family Therapy
American Civil Liberties Union National Prison Project
American Nurses Association
American Psychological Association
American Public Health Association
Association of State and Territorial Health Officials
Consortium of Social Science Associations
Fairness Fund
Human Rights Campaign Fund
National Association for Home Care
National Association of People with AIDS
National Association of Protection and Advocacy Systems
National Gay and Lesbian Task Force
National Minority AIDS Council

Ms. McGuire. Mr. Chairman, each time the council has come before you during the past 2 years, we have been reporting yet again the doubling of the diagnosed cases of AIDS. Today, we have surpassed 60,000, with 270,000 expected by 1991.

Our work and that of this committee, unfortunately within budget constraints, has just begun.

I want to begin by reinforcing Jeff's comments about the need to increase the capacity of the community-based organizations to provide the necessary prevention and education activities. If our goal is to change those behaviors that put individuals most at risk for the transmission of the virus, it is absolutely imperative that we house the prevention activities within the community-based organizations which are going to have the most access to and the greatest impact on the groups that we have targeted.

I want to focus the rest of my comments on the issue of direct care and the need to begin to allocate resources to better anticipate and respond to the care needs of AIDS patients which, in some areas, are already beginning to exceed the capacity of the existing health care systems.

To meet this pressing need, we have targeted new and considerably expanded funding for the Health Resources and Services Administration; an additional $5 million beyond the administration budget request to expand both the AIDS service demonstration centers and the pediatric AIDS service projects.

We are also recommending 10 million new dollars to fund up to four regional care projects to explore the feasibility of a regional system of response for medium and low prevalence areas of the epidemic.

We are proposing a new $100 million for special assistance programs to those communities which have been most heavily impacted. This impact aid approach is designed to meet what has become a health crisis in a number of communities, resulting in the depletion of resources available to support other acute, chronic, and preventive health care needs of otherwise poor and minority populations.

This program is not a solution to the long-term health care financing dilemma that is posed by AIDS, but would assure some immediate relief to already overburdened systems.

We are also proposing $10 million for planning grants to States, to assure that they will aggressively plan for the patient care needs that will be forthcoming. Recognizing that the fiscal constraints of this year may preclude aggressively addressing the care issue, at a minimum we must start the planning process that will lead us responsibly into the future care for these patients.

While we have incorporated other recommendations within our document, I will finish by pointing out only one.

It is imperative that we address the need to bring more health care professionals into this arena. Therefore, we have recommended both increases in current training programs and a loan forgiveness program that could otherwise attract individuals from diverse health care professions into both research and care opportunities.

PREPARED STATEMENT

Thank you for this opportunity to work with you and we will continue to work with you during the markup process.

Senator **Chiles**. Thank you both for your testimony. We appreciate your appearance here today.

[The statement follows:]

STATEMENT OF JEAN F. McGUIRE

Good morning, Mr. Chairman. I am Jean Flately McGuire, Executive Director of the AIDS Action Council. The Council is the only national organization dedicated solely to AIDS public health and policy issues. We represent the concerns of over 380 community based AIDS service organizations that provide direct social, health, and community education services throughout the country. I am here today to request your assistance in assuring that the good work this Subcommittee has begun can be expanded to meet what we unfortunately know is a growing need and challenge.

When the Council testified before you three years ago the number of reported cases of AIDS in the United States was 10,000. Two years ago, there were 19,807, and last year the number was 35,000. As of today, there have been 60,000 people diagnosed with AIDS in America, and we expect 270,000 cases of AIDS by 1991. The statistics are compelling and they more than suggest that no matter how laudable our efforts to combat the epidemic have been so far, they must be more than doubled if we are to keep pace. Therefore, the Council joins with our colleagues here today in calling for us to build toward a $2 billion annual AIDS research and education budget taking us to the National Academy of Sciences recommendation for AIDS spending by 1991.

Because others will be discussing the research and care components of the budget, I will be focussing today on funding for prevention activities. As you know there is presently no cure or vaccine for AIDS. Therefore, education of the American public about AIDS and its transmission has become the critical public health strategy in controlling the AIDS epidemic. The goal of this strategy is the successful modification of behaviors so that the spread of the virus is curtailed.

PREVENTION: EDUCATION

There are two levels at which the prevention education strategy must be implemented. First of all, the general public must have broader exposure to the facts about AIDS. America has lagged far behind some of our global neighbors who have undertaken considerable mass education campaigns, in spite of substantially lower infection rates. As a result, baseline information studies are already showing a greater public awareness among their general populations. The Surgeon General has certainly supported such an effort, and the mailer going out this month is an excellent, if long overdue beginning. But it is only a beginning, even the process of meeting the general public's needs. We believe however, that the more compelling, and the more productive education efforts are those which are targeted to and designed for those most at risk. We are beginning to see the positive effects of such targeted education efforts, both public and private. The incremental rate of infection for large segments of the white gay and bisexual male population is declining significantly. This does not suggest we should curtail our efforts targeted toward this very considerable at-risk group, but that behavior changes can be achieved and the spread of infection limited.

Unfortunately, AIDS prevention programs have not been sufficiently diversified and targeted to meet the need of the rest of the gay and other at-risk groups. As an indicator, we note with alarm the increase in other sexually transmitted diseases among the heterosexual Black and Hispanic communities, and continuing modest increases among homosexual/bisexual Black and Hispanic men.

Looking at present projections indicating that approximately 1 to 1.5 million Americans are currently infected with the AIDS virus, it is eminently clear that a comprehensive, federally-funded national education campaign is needed. A campaign that makes all Americans feel AIDS effects them directly as a person potentially at risk and a campaign that succeeds with those most at risk. A diverse public and private partnership is required to reach the general public as well as target groups.

We feel strongly that prevention programs succeed when:

- information presented about AIDS is factual, clear and age appropriate;
- programs are geographically and culturally sensitive;
- programs are designed to reduce the hysteria and irrational fears associated with the disease;
- collaboration among local and state health officials, community based organizations, community leaders occurs at the local level;
- activities are undertaken by trained individuals;

- information targets individuals exhibiting high risk behaviors such as: unprotected intercourse, intravenous drug abuse, etc.; and

- programs use creative forms of outreach to target groups, e.g. - addressing youth and adolescents at risk through schools and street based education efforts.

Prevention programs will not work effectively if activities are not housed, in large part, in those community based organizations which have the greatest access to those most in need. Therefore, allocations for education prevention activities should target the special and necessary role of these organizations.

Effective prevention also depends on structured planning and evaluation activities. Special planning and evaluation grants are needed for state agencies to assure that public and private partnerships in the education dissemination process are developed and are reviewed to determine their efficiency. We support a grant program federally funded to effect such State planning, collaboration and review.

The Council is extremely concerned that we adequately address the problem of AIDS in minority communities. The Administration's efforts so far have not reached to this pressing issue, in spite of the fact that AIDS is having a disproportionately high impact on these communities. These communities often lack organized community based support structures that have been the cornerstone of successful efforts in other groups so far. Therefore, we urge the funding of $100 million for prevention efforts within the minority community. The Office of Minority Health and the CDC must collaborate in this venture with the leadership being vested in minority community based and national minority organizations to ensure success.

Sexually transmitted disease (STD) clinics are critical to the success of AIDS prevention programs. The growing evidence indicates that other STDs may be a cofactor in the development of AIDS. Funding for STD behavior studies should be dramatically increased over the Administration's recommended $65 million. STD funding can not be diverted to support AIDS prevention programs. STD prevention is a critical part of AIDS prevention efforts.

Before leaving the prevention education discussion I must note the very chilling effect on information dissemination efforts which was caused by the Helms amendment added during the passage of the Continuing Resolution in December. We know from many of the community based organizations that at a minimum that amendment has led to dramatic self-sensorship, at the risk of reducing program effectiveness. Moreover, funds have stopped flowing to some of those entities whose prevention education efforts have been most productive. We know this cannot be what members had envisioned, but it is what is now happening. We urge you to explore ways in which we can turn back the clock on this restrictive and dangerous policy.

PREVENTION, TESTING AND COUNSELING

It is with some degree of hesitancy that I approach the area of testing... not because AIDS Action Council hasn't reviewed testing policies. In fact, along with many of the National Organizations Responding to AIDS (NORA), we are on record as supporting expanded voluntary anonymous testing and counseling services. We are clear that, as an adjunct to the counseling and education efforts, testing can assist in improving the outcome of prevention activities. However, this Administration has all too frequently equated an HIV testing agenda with prevention. This posture ignores the premise that the goal is the behavior change which cannot be effected by testing alone, particularly if the test results are negative. It is the counseling component of a testing program which encourages and reinforces the behavioral changes necessary to reduce the risk of infection of HIV.

Along these lines, the Surgeon General of the United States, the Institutes of Medicine Committee on the National Strategy for AIDS, the American Medical Association, and the public health community have rejected the use of mandatory HIV testing and have unanimously recommended that HIV counseling and testing be offered in voluntary programs, except in the case of donation of organs or body fluids. In fact, the Surgeon General's widely circulated report has noted that "compulsory blood testing of individuals is not necessary. The procedure could be unmanageable and cost prohibitive. It can be expected that many who test negatively might actually be positive due to recent exposure to the AIDS virus and give a false sense of security to the individual and his/her sexual partners concerning necessary protective behavior."

The AIDS Action Council recommends the expansion of testing programs that are: voluntary and anonymous in health care settings where persons at high risk avail themselves of medical care and counseling. These settings should include, among others, STD clinics, community based AIDS service organizations, maternal/child health clinics, family planning clinics, rehabilitation programs, community health centers and migrant and Indian health centers.

The Administration has requested almost $100 million for testing programs. Consistent with what I have said, funding for testing without sufficient resources for counseling will do little toward the goal of reducing the rate of transmission of AIDS. Therefore, we recommend approximately another $100 million for comprehensive testing and counseling services.

As we pursue a Federal AIDS testing policy, and the funding for these activities, it is important to remember that the integrity of the HIV antibody test itself is presently a matter of controversy. The public health community has voiced concern that wide spread HIV testing among low risk groups may actually increase the number of "false positives" found in low incidence populations. A recent report of the Office of Technology Assessment (OTA) on antibody testing demonstrated that false positive rates of up to 33 percent occurred in laboratories that frequently test for HIV antibodies, and false positive rates of up to 90 percent in laboratories which perform the test infrequently. Therefore, the Council recommends that a laboratory analyzing HIV tests should participate in the CDC's laboratory proficiency program. The potential impact of false test reports on individuals is significant. We must be able to assure that HIV antibody tests are accurately performed in accordance with the CDC standards. The Administration plan to delay CDC funding for this program must not occur.

In addition to our specific prevention recommendations, the Council urges the Committee to evaluate the following Administrative actions to secure effective federal AIDS programs. The Council recommends that the Committee:

- reject the Administration's request that fiscal 1989 funds "remain available until expended";
- reject the creation of a single AIDS account at the Public Health Service that would create another level of bureaucracy, delaying the availability of funds;

- reject the establishment of a $15 million contingency fund in OASH; and

- oppose the consolidation of the PHS/CDC prevention and surveillance activities into a state block grant program by the CDC.

The Council urges the Committee to evaluate the following management problems to secure appropriate use of appropriated funds:

- prevent administrative authority to stretch expenditures over an indefinite period;

- allocate sufficient full time equivalents to assist staff to handle the increased activities of the federal AIDS programs; and

- oppose the PHS authorization power to reprogram 3 percent of non-AIDS budget to AIDS.

Through this Subcommittee's actions we have the opportunity to assure the development of effective AIDS prevention education and counseling and testing programs. Your assistance in developing this critical public health strategy is of the utmost importance. The AIDS Action Council stands ready to assist you in your continuing deliberations. On behalf of the National Organizations Responding to AIDS, we will be submitting a more comprehensive appropriations statement shortly.

STATEMENT OF ANNA MAE KATTNER, PARENT AND MEMBER OF THE FEDERATION OF PARENTS AND FRIENDS OF LESBIANS AND GAYS, INC.

Senator **Chiles**. Now we will hear from Anna Mae Kattner, parent, and member of the Federation of Parents and Friends of Lesbians and Gays, Inc.

Ms. **Kattner**. Mr. Chairman, my name is Anna Mae Kattner, from Philadelphia, PA, a member of Parents and Friends of Lesbians and Gays.

Our son died on September 30, 1987, of AIDS.

An increase in the budget to at least $1.3 billion is vitally important to meet the expanding needs of education, research, treatment, and care for this disease, and for the protection of the Nation's health.

Sharing our experience of the living horror of this disease will hopefully affirm your commitment to this budget that will be the means to abolish AIDS.

Joseph was the youngest of our four sons. He attended 12 years of private schools and was a graduate of Columbia University. He was an accomplished musician, Life Scout, swimmer, and scholarship recipient for high school and Columbia.

Our hopes and dreams for our son were shattered by a phone call June 18, 1986, from a doctor, telling us he had AIDS.

We had no inkling of our son's homosexuality prior to that call.

Let me now read from a letter which we later learned Joseph had written during his first weeks of hospitalization.

> Anyway, the foolishness of my college days have caught up with me and I have AIDS. I apologize for being so curt on the phone last week, but I had a high fever and several nurses were poking about. The news at first frightened me. I wanted to know about euthanasia laws. I was blaming myself and dreading having to tell my parents, but when I told them, they were so loving and gentle that my fears vanished. It was as if angels lifted lead weights from my shoulders. Now I'm confident that I can take what the Lord sends me.

During those 46 days in the hospital, we saw our independent, vibrant, young son reduced to complete dependency. Cut off from all his earning capabilities, career, independence, his family became his hope. Financially, physically, and mentally, we were not prepared for this journey.

We researched all conduits of education; support groups for the family, for our son, hot lines, parents and friends of lesbians and gays, a buddy system for people with AIDS.

Caring for Joseph was a day-to-day necessity. His father, who is retired, became his personal nurse, caring for him at home and staying with him each day during his hospital stays.

Doctor Buckley, our son's physician, referred us to the Hospice Program at Pennsylvania Hospital. The service was a blessing, and nurse Mary McDonough and social worker Betty Carr visited our home each week to check on our son and the family.

As a family, we were uniquely fortunate. There were no charges for this hospice program's services.

Others who are suffering from this disease and do not have the same family support also need a family caring program.

After struggling with the disease for 16 months, Joseph died in our bedroom last September. These dedicated and loving caretakers were with us every step of the way. These same people, the doctor, nurse, and a mother from our support group, whose son also died of AIDS, have since made an educational videotape for use in our community.

PREPARED STATEMENT

We believe that these resources were absolutely vital and should be made available to every family who must face up to this dreadful disease. Education will not only help stop the spread of AIDS, but make known to families like ours what help is available. Finally, research may some day bring a cure that will spare other families our pain.

Thank you.

Senator CHILES. Thank you very, very much for your testimony.

[The statement follows:]

STATEMENT OF ANNA MAE KATTNER

MR. CHAIRMAN, MY NAME IS ANNA MAE KATTNER, FROM PHILADELPHIA, PA, A MEMBER OF PARENTS AND FRIENDS OF LESBIANS AND GAYS. OUR SON DIED ON SEPTEMBER 30, 1987 OF AIDS.

AN INCREASE IN THE BUDGET TO 1.3 BILLION IS VITALLY IMPORTANT TO MEET THE EXPANDING NEEDS OF EDUCATION, RESEARCH, TREATMENT AND CARE FOR THIS DISEASE AND FOR THE PROTECTION OF THE NATION'S HEALTH. SHARING OUR EXPERIENCE OF THE LIVING HORROR OF THIS DISEASE, WILL HOPEFULLY AFFIRM YOUR COMMITMENT TO THIS BUDGET THAT WILL BE THE MEANS TO ABOLISH AIDS.

JOSEPH WAS THE YOUNGEST OF OUR FOUR SONS. HE ATTENDED 12 YEARS OF PRIVATE SCHOOLS AND WAS A GRADUATE OF COLUMBIA UNIVERSITY. HE WAS AN ACCOMPLISHED MUSICIAN, LIFE SCOUT, SWIMMER, SCHOLARSHIP RECIPIENT FOR HIGH SCHOOL AND COLUMBIA. OUR HOPES AND DREAMS FOR OUR SON WERE SHATTERED BY A PHONE CALL AT MY PLACE OF EMPLOYMENT, JUNE 18, 1986, FROM A DOCTOR TELLING ME JOSEPH HAD AIDS. THE DOCTOR THEN CONTINUED TO SAY "WHAT ELSE SHOULD WE EXPECT - YOUR SON WAS GAY, HAD AIDS, LIVED AND WENT TO SCHOOL IN NEW YORK". JOSEPH'S MOST PAINFUL JOURNEY WAS BEGINNING. WE TOLD HIM WE LOVED HIM, HE WAS OUR SON AND WE WERE WITH HIM ALL THE WAY. WE HAD NO INCLINATION OF OUR SON'S HOMOSEXUALITY PRIOR TO THAT CALL.

LET ME READ FROM A LETTER WE LATER LEARNED THAT JOSPEH HAD WRITTEN DURING HIS FIRST WEEKS OF HOSPITALIZATION. "ANYWAY THE FOOLISHNESS OF MY COLLEGE DAYS HAVE CAUGHT UP WITH ME AND I HAVE AIDS. I APOLOGIZE FOR BEING SO CURT ON THE PHONE LAST WEEK, BUT I HAD A HIGH FEVER AND SEVERAL NURSES WERE POKING ABOUT. THE NEWS AT FIRST FRIGHTENED ME. I WANTED TO KNOW ABOUT EUTHANASIA LAWS. I WAS BLAMING MYSELF AND DREADING HAVING TO TELL MY PARENTS, BUT WHEN I TOLD THEM, THEY WERE SO LOVING AND GENTLE THAT MY FEARS VANISHED. IT WAS AS IF ANGELS LIFTED LEAD WEIGHTS FROM MY SHOULDERS. NOW I'M CONFIDENT THAT I CAN TAKE WHAT THE LORD SENDS ME."

During those 46 days in the hospital, we saw our independent, vibrant young son reduced to complete dependency. Cut off from all his earning capabilities, career, independence, his family became his hope. Financially, physically and mentally, we were not prepared for this journey. Our son was placed in the care of Dr. Michael Buckley and his associates, Dr. Braffman and Gluckman from Pennsylvania Hospital. His medical expertise and understanding of the disease, with its effect on the patients and their families, were our strength. Our oldest son, a lawyer, became a personal information center, and researched all areas of education for support groups for the family and Joseph.

Before and during his illness, Rev. James Casiotti, S. J., stationed at Old Saint Joseph's Church in Philadelpha, was Joseph's spiritual director. He gave that needed internal strength and support, spiritually and as a friend, which maintained Joseph's deep commitment to his faith. That same outpouring of acceptance was shared with our whole family and continues to this day. Joseph's eulogy, written and delivered by Father Casiotti, is attached.

Caring for Joseph was a day to day necessity. His father, who is retired, became his personal nurse, caring for him at home and being with him each day during his hospital stays. Each Sunday, Joseph attended a support group at Graduate Hospital from 2 - 4 pm. There he shared with others who had the disease. Through funding, he attended a week-end seminar which motivated him to think positively, be strong and truly courageous in spirit. As the disease took its toll, we reached out to all areas of education. The "buddy" system was offered to Joseph, he was not ready at first, but when he was, the "buddy" assigned to him, a female medical student, proved to be that marvelous link of strength that comes from people who care.

Dr. Buckley referred us to the Hospice Program at Pennsylvania Hospital. What a blessing! The nurse, Mary Mc Donough, would visit

Joseph at home. Also, a social worker, Betty Carr, who visited our son and family to follow up on our needs, such as medical supplies, and our psychological well being.

After struggling with the disease for 16 months, Joseph died in our bedroom this last September. These dedicated and loving caretakers were with us every step of the way. These same people, the doctor, nurse and a mother from our support group, whose son also died of AIDS, have since made an educational video tape, for use in our community. Attached are announcments where they have presented their panel, as well as an ongoing ministry program for AIDS, for those who are ill, their families, friends and caretakers, in one of our downtown churches in Philadelphia.

We believe that these resources are absolutely vital and should be made available to every family who must face up to this dreadful disease. Education will not only help stop the spread of AIDS, but make known to families like ours, what help is available. And finally, research may someday bring the cure that will spare other families our pain.

LETTER FROM ANNA MAE KATTNER

3248 Wellington Street
Philadelphia, PA 19149
June 2, 1987

President Ronald Reagan
The White House
Pennsylvania Avenue
Washington, DC

Dear President Reagan:

Listening to the current news reports and finally reading the Inquirer this morning on the way to work, I felt it was imperative that I write to you. June 18, 1986 I received a call at my offfice telling me to come to Mt. Sanai Hospital in New York City immediately, our son Joseph was admitted with AIDS. The doctor then continued to say what else should I expect. My son was gay, had AIDS, lived and went to school in New York. As parents, like you and Mrs. Reagan, we were devastated by the news. We did not know our son was gay and knew very little about AIDS. At this present date we have learned volumes and wish to share some of that with you, and also your Vice President, Mr. Bush, who was heard to remark over the micro phone yesterday at his address to the International Conference on Aids, "who was that, some gay group". Perhaps there were, and probably some of the finest human beings you will ever meet.

The reason for this letter; I would like to invite you and Mrs. Reagan to meet and talk to our son, now in Pennsylvania Hospital and in the last stages of the disease. Arrangements are now being made to set up our dining room as his hospital room with the hope that he will be with his family at his death. His doctor is Michael Buckley, and without his medical expertise and support, such as the Hospice Program, his medical staff, Dr. Stephen Gluckman and Dr. Michael Braffman, we cannot imagine where we would be without them.

The ultimate teacher is experience. If you and Mrs. Reagan have not had the opportunity to speak to a patient, family, doctor, see and visit a hospital that is dealing with AIDS, here is an opportunity. I know you will realize immediately the urgency for funding to research and find avenues of treatment and someday a cure for this insidious disease. Testing is one way of dealing with the disease but experiencing it is the teacher that tells all. Attached is our list of names and telephone numbers to reach us. Please hurry, for many, time is running out - it will be an unforgettable visit.

Sincerely,

Anna Mae Kattner

LETTER FROM FREDERICK J. RYAN, JR., DIRECTOR OF PRESIDENTIAL APPOINTMENTS AND SCHEDULING, DIRECTOR OF PRIVATE SECTOR INITIATIVES, THE WHITE HOUSE

THE WHITE HOUSE
WASHINGTON

July 7, 1987

Dear Mrs. Kattner:

On behalf of the President and Mrs. Reagan, I want to acknowledge your invitation to visit with your son, Joseph.

We appreciate your extending this opportunity to the President and the First Lady, and I regret to write that, due to the heavy demands on their schedules, they will be unable to accept your kind invitation. However, they asked me to convey to you their sincere thanks for your thoughtfulness and want to extend to you and your son their very best wishes.

Sincerely,

Fred Ryan

FREDERICK J. RYAN, JR.
Director of Presidential Appointments
and Scheduling
Director of Private Sector Initiatives

LETTER FROM ANNA MAE KATTNER

3248 Wellington Street
Philadelphia, PA 19149
March 24, 1988

President Ronald Reagan
The White House
nnsylvania Avenue
Washington, D.C.

Dear President Reagan:

Tuesday, March 22, 1988, a group of parents and relatives met with their respective state Senators, namely, Maryland, New York, Pennsylvania and Virginia, to encourage passage of S1220. All along the way, the deterrent mentioned was Mr. Jesse Helms. We visited Mr. Helms' office on Tuesday, around 5:15pm and left a packet of information.

In our group, many of us have lost a member of our family to AIDS. We have lived through the horror of this disease. When the disease attached our loved ones., we experienced the closed doors - education about AIDS not encouraged, research repressed - and discrimination, especially to gay men, was painfully evident. Much to their credit, the gay community has been an educator for this insidious disease for restraint and control in their lifestyles.

Attached is a letter I wrote to you in June, 1986. Our son Joseph ed September 30, 1987. A copy of S1220 was sent to Joseph in late June, we encouraged our friends to read and become familiar with its content - here we are March, 1988 - no action.

Mr. President, please meet with Mr. Helms. Let him or both of you, visit a hospital and walk the rounds with a doctor who has AIDS patients, talk to a family who is experiencing the disease. Children, women and minorities are now being affected in large percentages and the AIDS issue is a public health concern.

How thankful I am to Senator Heinz from my state of Pennsylvania, who is now a co-sponsor for S1220. He and his staff are going in the right direction, education. In my community, Philadelphia, efforts are continuing for education. As you can see from the attachments, this is happening through different facets. With the expertise of our son's doctor, his nurse from the Hospice program and a mother who lost her son, we now have a video tape to be used educationally. There is also a ministry program in downtown Philadelphia. Talk to any care takers or families involved with the patients and their message comes through loud and clear, education, research, home health care - needed now.

If I can be of further help, please let me know.

Sincerely,

Gloria Mae Kattner

WE EXTEND AN INVITATION TO YOU, YOUR BOARD MEMBERS, YOUR STAFF, YOUR CONGREGATION, YOUR NEIGHBORS, FAMILY AND FRIENDS TO ATTEND A...

Forum on AIDS

THURSDAY, FEBRUARY 25, 1988
8:00 P.M.

in the cafeteria (ground level) of
ST. MARGARET PARISH SCHOOL
227 N. Narberth Avenue
Narberth, PA

Moderator: SISTER MAUREEN LOWRY, RSM
President of Mercy Catholic Medical Center

Speakers

JEAN BELL
American Red Cross/Main Line Branch

R. MICHAEL BUCKLEY, MD
Infectious Disease Section of Pennsylvania Hospital
Clinical Associate Professor of Medicine/University of Pennsylvania

MARY VEITH, ACSW
Director of Social Service/St. Agnes Medical Center

MARY B. MC/DONOUGH, RN, MAPC
Hospice Program/Pennsylvania Hospital

Benediction: REVEREND ORION A. EICHNER
Pastor of Holy Trinity Lutheran Church

(This "Forum on AIDS" is being sponsored by the Narberth Area Ministerium)

Contact Persons

SHARON BYRNE (664-4436) and MARIE MC/CLOSKEY (664-4691)

"MUCH MORE REMAINS TO BE DONE: AS A FIRST STEP WE MUST BUILD TRUST AND A SENSE OF CARING. THESE REQUIRE TIME, A CHANGE OF HEART AND CONSIDERABLE EDUCATION."

FRANCIS A. QUINN
BISHOP OF SACRAMENTO

AIDS

RESPONSE OF A CARING COMMUNITY

FRIDAY, MARCH 11, 1988

7:30 p.m.

Plymouth Friends Meeting House
Butler Pike & Germantown Pike, Plymouth Meeting , Pa.

MODERATOR

Rebecca Cratin, Montgomery County AIDS Task Force

SPEAKERS

DR. NICHOLAS IFFT, M.D., on the staff of Pennsylvania Hospital and S.E. Health Center

MARY VEITH, ACSW, Director of Social Services, St. Agnes Medical Center

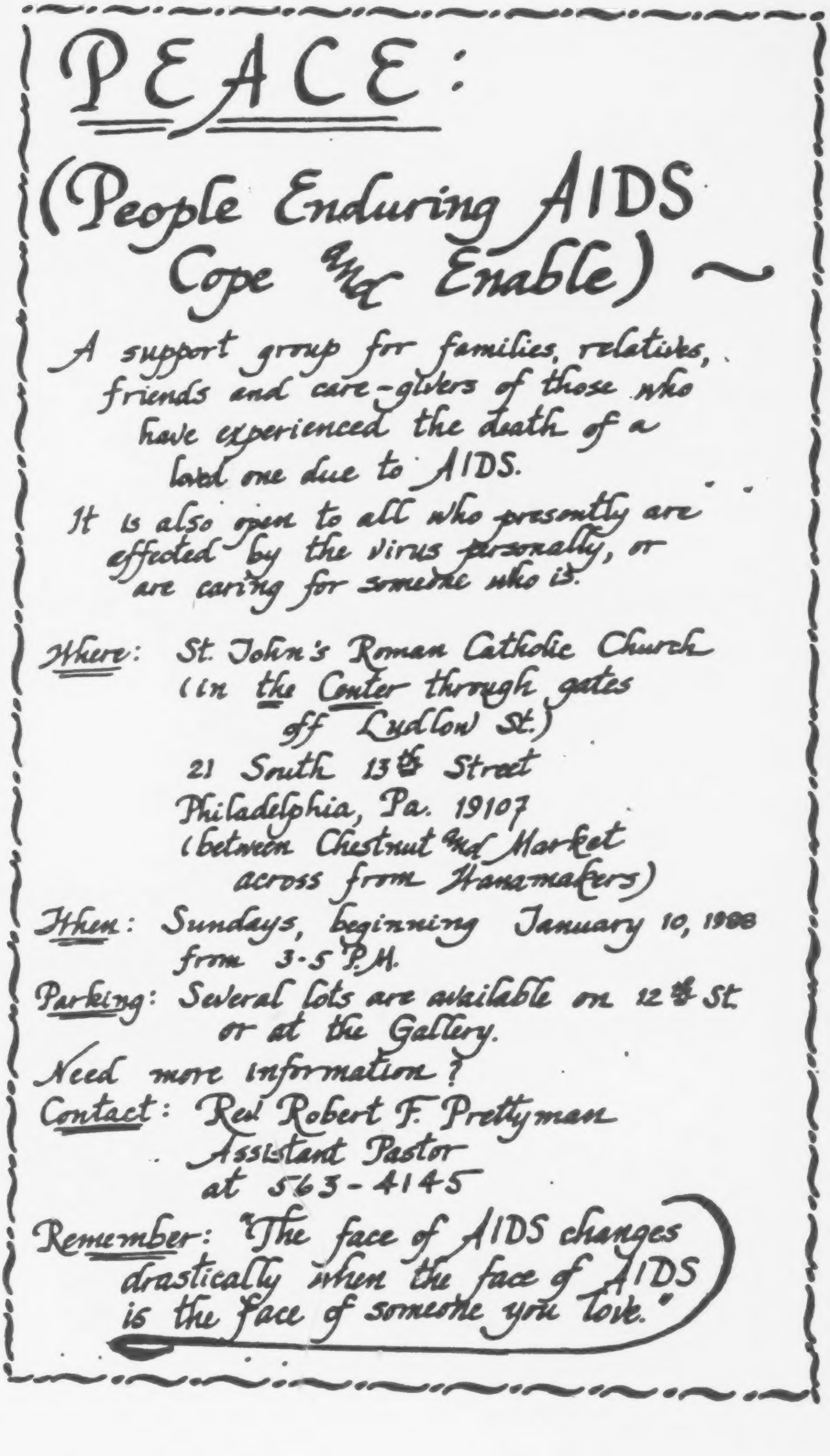
MARY MC DONOUGH, R.N., Home Care Nurse, Pennsylvania Hospital, AIDS Hospice Program

FILM

" BEYOND FEAR", American Red Cross

You are invited to bring your concerns and questions as we explore the facts about AIDS and ways in which we can respond as caring members of the community to those who need our help.

CHILD CARE WILL BE PROVIDED



PEACE:

(People Enduring AIDS Cope and Enable) ~

A support group for families, relatives, friends and care-givers of those who have experienced the death of a loved one due to AIDS.

It is also open to all who presently are effected by the virus personally, or are caring for someone who is.

Where: St. John's Roman Catholic Church
(in the Center through gates
off Ludlow St.)
21 South 13th Street
Philadelphia, Pa. 19107
(between Chestnut and Market
across from Wanamakers)

When: Sundays, beginning January 10, 1988
from 3-5 P.M.

Parking: Several lots are available on 12th St.
or at the Gallery.

Need more information?

Contact: Rev Robert F. Prettyman
Assistant Pastor
at 563-4145

Remember: "The face of AIDS changes drastically when the face of AIDS is the face of someone you love."

FUNERAL: JOSEPH KATTNER

Many of you know that Joe wanted his funeral to be here because he especially liked Jesuit preaching. I fear I may disappoint him today. In the face of such suffering for him and his loved ones, any attempt at eloquence by me would be hollow and irritating. I'll let Joe be the eloquent one by closing with sections of a letter he wrote after receiving his diagnosis.

First what I have to say. You can have two understandings of the past 15 months: (A) Is there a God? If there is, He is powerless, indifferent, or masochistic. (B) You can discover in Joe's death the pattern of the Lord's death and resurrection--the Sacrament of Innocent Suffering.

This choice is what the Good Thief is all about. As Jesus hangs on the cross, one criminal taunts Him: "If you are really the Messiah, really so damn powerful and compassionate, get down! Save yourself and us!"

The other criminal, even in his own suffering and sin and failure, experiences the Passion of Jesus and enters paradise. A little definition: "Passio" not any kind of suffering, but suffering chosen, accepted, suffering FOR something, with a purpose. As one writer said, one does not undergo martyrdom, one performs it. "No one takes my life from me, I lay it down." The Agony in the Garden, the human revulsion before torture, betrayal and abandonment, becomes the last triumphant word of the dying Jesus in John's gospel: "Finished."

The purpose of the Passion of Jesus is to bring us to PARADISE. Note that Jesus says "This night in paradise" when we are plainly told that He goes to the Father 40 days after the Resurrection. Paradise is not a particular geographic place. Paradise is being in the presence of God whose love for me and for us is relentless, eternal, affectionate. Jesus on the cross is THE sign: "Who sees me sees the Fr." "No matter what--whatever evil and fear produces in human history, no matter what you think of Me (ignore, spit, ridicule), I love you, I create you, I forgive you."

That kingdom, that paradise, that belonging to God is deep within each of us, origin and destiny. However we only know it when something breaks through and draws it out. The innocent suffering of Jesus draws out the cumpassio of this man, afraid and embittered by life. The Thief was not innocent, Joe was not innocent, you and I are not innocent. But that doesn't matter. As we sing at the Easter Vigil, our sins are the Happy Fault which gains us so great a Redeemer. What matters is joining my suffering to His . What matters is letting Him love me and others through me. The Good Thief ACCEPTS his suffering and joins it to the Passion of Jesus. In this compassion, the Church is born and the first of the redeemed enters paradise.

Allowing the suffering of Jesus to transform us and others is the pattern for Xtn life. God gives us no answer for human suffering except the command of the Good shepherd who lays down His life for the sheep: "Feed my lambs, feed my sheep!" "You have been addicted, or widowed, or promiscous, or gone bankrupt, or been divorced or had a masectomy. You know the pain; reach out to others. You have sinned and been forgiven; let it teach you compassion for others who fail or betray or are just plain dumb. Your son is gay and has AIDS; help other parents to understand and to love and not to turn away."

The ancient, origin-al choice is there. Grow in isolation and cynicism and curse God. This day can be another duty done and forgotten and Joe's last months a nightmare to be repressed. Or, grow in the compassion through which God heals others and which puts you, even on this day, in paradise.

We are about to offer the Sacrifice of Innocent Suffering. Joe's Passion and the Passion of the Lord made visible in the Eucharist which Joe loved so much. No one's life is wasted, for nothing.

If one person is moved, if one person hears the gentle, urgent command, "Feed my lambs, feed my sheep," Joe's life will have been a sacrament for us all. You could pay him no greater honor.

Now I'll let Joe speak from a letter written during his first hospitalization in New York:

My dear brother Conrad, whom I respect alot, although he is both a crew-jock and yuppy lawyer, is sweet and honest to the core. He's the one who left a message for you about my being in the hospital, without my knowing it. But I'm glad he did. Please pray for me.

"It was a fluke that I started to attend Old St. Joe's. I was extremely stirred. I cried. I knew I'd have to keep coming back...You can imagine the solace the painting with the Magdelene at the foot of the cross gave me. Here in New York, I've been attending Solemn Mass at St. Ignatius. They leave me quaking with ecstacy...

"Anyway, the foolishness of my college days have caught up with me, and I have AIDS. I apologize for being so curt on the phone last week, but I had a high fever and several nurses were poking about... The news at first frightened me; I wanted to know about Euthenasia laws. I was blaming myself and dreading having to tell my parents. But, when I told them, they were so loving and gentle that my fears vanished. It was as if angels lifted lead weights from my shoulders. The only thing they said was, "We never raised you for that lifestyle"...The reality had been confronted.

"My attitude now is much better. Fighting the fevers taught me patience...Now I'm confident that I can take what the Lord sends me. After all, I am His and He loves me."

STATEMENT OF JAMES R. KLINENBERG, VICE PRESIDENT, CEDARS-SINAI MEDICAL CENTER, LOS ANGELES, CA

Senator CHILES. Now we will hear from Dr. James Klinenberg of Cedars-Sinai Medical Center in Los Angeles.

Dr. KLINENBERG. Thank you, Mr. Chairman and distinguished members of the committee. I am Dr. James Klinenberg, the vice president for professional services at the Cedars-Sinai Medical Center and director of the Cedars-Sinai Medical Research Institute.

I have submitted prepared testimony on the need for funding of construction of health research facilities as well as the provision of equipment and instruments for these facilities, and I will only make a few comments to emphasize the importance of this type of legislation.

The demand for new research facilities has been created first, because no general facility construction support has existed since the 1960's. Second, there has been significant expansion, as you have heard, of the need and support for research. Finally, most importantly, there has been a change in the nature of research, from physiology and biochemistry, to a significant emphasis on the new biology, molecular biology, and the very important new types of vistas which that opens up for us.

The Cedars-Sinai Medical Center is an academically oriented community hospital that is in a unique position to help in bringing the translation of major new research discoveries to where it is so important, and that is to direct patient care.

I will comment on three activities that we are involved in. One of them is in medical genetics and the prevention of birth defects, the very important mapping of the genome, and the ability to relate one's heredity to a variety of common diseases.

We are actively involved in AIDS research, looking for ways to prepare that vaccine which will, hopefully, alleviate the problem for the future, and we are doing some very exciting work with the excimer laser, which has the potential for opening up plugged vessels, both in the heart and in the periphery, and we should hope to have this as a real boon to the future treatment of a whole host of vascular diseases.

The successful pursuit of these exciting areas requires expensive facilities, equipment and instrumentation.

I urge the members of this subcommittee to pursue a program for financial assistance for the construction of these facilities, which are required to insure that these vital new efforts in research are brought to fruition.

PREPARED STATEMENT

In closing, this investment in medical research will be one of the soundest investments the Government can make. We believe that the outcomes will both reduce morbidity and the attendant cost to the medical care providers, as well as prevent the occurrence of many conditions which otherwise will cost this country untold billions of dollars.

We thank you for your consideration.

Senator CHILES. Thank you very much, Doctor, for your testimony.

[The statement follows:]

STATEMENT OF JAMES R. KLINENBERG

Mr. Chairman, Members of the Committee, I am James R. Klinenberg, Vice President of Cedars-Sinai Medical Center in Los Angeles, California. Cedars-Sinai, a world renowed medical center, has long been committed to excellence in patient care and research. We are, however, a classic example of a major health resource which suffers from antiquated, inadequate facilities and equipment. The situation in which we find ourselves is, unfortunately, not unique. The dynamic nature of research, the constantly expanding technology requires continuous updating of facilities and equipment.

Cedars- Sinai, like so many other research centers requires medical facilities construction assistance. Additionally, as an institution which has made a major commitment to AIDS research, we require expanded facilities for these endeavors. Severely limited resources often result in the diversion of research efforts. For example, if additional finances and manpower are required for AIDS research, this results in a decrease of time, money and effort for other vital areas of research.

The Congress has always recognized that a strong medical research enterprise is the only way to reduce human suffering and death. However, without a full appreciation for the importance of state-of-the-art facilities, instrumentation and equipment, its prospects for advances in medicine will be grim.

I strongly support the position of the Ad Hoc Group for Medical Research Funding and would like to highlight some points which I believe deserve your attention and support.

The strength of any research enterprise is based on the sum of its parts - the infrastructure is multi-faceted. All parts of it must be supported in order to insure meaningful research results. These needs include facilities, equipment, people, animal resources and special programs. New general construction authority is essential to insure that high quality research can be undertaken.

Researcher's must have access to the most advanced scientific instrumentation if their efforts are to glean results.

The 1985 amendments to the animal welfare act and the 1985 PHS policy were designed to insure humane care and treatment of laboratory animals which are so critical to biomedical and behavioral research efforts. It is estimated that these new regulations will place a financial burden on the nations' research facilities of hundreds of millions of dollars. If provisions are not somehow made to assist research facilities in obtaining funding to insure compliance with the new regulations, it is anticipated that many sound research programs will simply be discontinued.

Significant resources need to be directed towards clinical trials. If provisions are not made for this component of the research process, the full benefits of basic and biomedical research will not be realized.

Finally, obsolete facilities must be replaced and/or renovated to allow for expansion of research programs. The last NIH facilities grant was made in the 1960's. While most universities and hospitals have borrowed money or appealed to the private sector for financial support to construct and renovate research facilities, the fact is that need has far surpassed the ability to keep pace. In addition, new restrictions on tax-exempt bond financing preclude the option of borrowing to build for many institutions.

Cedars-Sinai has, through its research efforts, developed a number of clinical programs which have directly saved countless lives. Our program in laser research has resulted in the Excimer Laser - a technique which allows for the non-invasion removal of blockages of the arteries. The full potential for the Excimer Laser and the concepts upon which it is based have not yet been realized. However, expanded programs and new technologies are doubtful without concomitant updated, expanded facilities.

I respectfully request that the Committee review this situation carefully. Without a major commitment to the biomedical research infrastructure, our hopes and dreams for a healthier future will be beyond our grasp.

STATEMENT OF JOE JOHNSON, VICE CHANCELLOR FOR RESEARCH AND DEVELOPMENT, ATLANTA UNIVERSITY CENTER, AND CHAIRMAN, MINORITY BIOMEDICAL RESEARCH SUPPORT PROGRAM DIRECTORS' ORGANIZATION, ATLANTA UNIVERSITY

Senator CHILES. Now we will hear from Joe Johnson, the chairman of the Minority Biomedical Research Support Program Directors' Organization, of Atlanta.

Dr. JOHNSON. Thank you, Mr. Chairman.

Mr. Chairman, members of the subcommittee, I am Dr. Joe Johnson, vice chancellor for research and development of the Atlanta University Center. I am also president of the Minority Biomedical Research Support Program Director's Organization, and it is in this capacity that I direct my comments to this committee.

Several studies have indicated over the years that, in fact, this country is losing its potential in science and technology as a result of the fact that it is not training human resource development in the minority community.

By the year 2000, 35 percent of the total population of college bound students will be of minority representation.

But it is in my capacity as president of this organization that it is incumbent on me and it is my duty-bound responsibility to point out to this committee that human resources in the minority community represent a potential for development for the support of the human resource development of this country.

David Hamberg, president of the Carnegie Corp., indicated that, indeed, this is an untapped resource that must be developed and must be pushed to the ultimate limit. For this purpose, I propose to this committee that we initiate new health development in this country, dealing with the initial development of high school students for the purpose of increasing the pool of underrepresented minorities in this country; that, in fact, we allocate funds for this development—$2 million in 1989 and $4 million in 1990; increasing to the year 2000, to the point where the propensity for the human resource development would level off in terms of the total global population in the United States of college bound kids. This minority group must be developed and must be pointed to as a potential resource for science and technology development in this country.

I testified before the House committee, with Representative Natcher of Kentucky, and in that testimony, there was clear evidence that he was touched by the opportunity and the possibility that, indeed, we concentrate and push to the ultimate limit, that indeed there is a potential resource for the scientific and technological development of this country.

I would like to make a few statements about the Center for Disease Control in Atlanta and its report of September 8, 1986, where 25,000 cases of AIDS were reported at that time; 25 percent of that total population was black; 14 percent was Hispanic.

We represent only 12 percent of the total population, and Hispanics only represent 6 percent. Yet the disproportionality that exists is staggering. It is frightening.

Something has to be done about it.

For example, one example and one example alone, the Division of Research Resources has $50 million allocated for AIDS research, and not one dime, not one nickel, not one penny, has been allocated for the education of minorities.

This is troubling. This is disgusting.

But, in terms of the research and development of this country, of this Nation, certainly it represents the best that the world can ~~offer.~~ But, somehow, it is not trickling down to minority institutions, to minority people.

I hope that in your last try at this effort, you will bless me with support and help.

In 1968, I taught at Bethune-Cookman College—for 2 years. I left Bethune-Cookman College and I went to the Atlanta University Center. During that time, I have trained 45 minority students at the Ph.D. and masters levels.

I am very proud of that.

PREPARED STATEMENT

It is difficult, with limited resources, to continue to fight for what you believe are the opportunities awarded to anyone else in the society.

I thank you very much, Mr. Chiles, for your support.

[The statement follows:]

STATEMENT OF JOE JOHNSON

Mr. Chairman, members of the subcommittee, I am Dr. Joe Johnson, Vice Chancellor for Research and Development at Atlanta University Center. I am also the President of the Minority Biomedical Research Support (MBRS) Program Director's Organization. It is in this capacity that I address the Committee.

INTRODUCTION

Several studies have clearly shown that if this country does not better prepare its youth in science and math - at a much earlier age - and increase the pool of potential scientists at all educational levels, it will eventually lose its superiority in science and technology. Even more recent studies indicate that the country imports an alarming percentage of its research talent from abroad - while vast human resources go untapped at home.

Black colleges comprise a mere three percent (3%) of all undergraduate institutions but confer forty percent (40%) of all degrees earned by Blacks. And, though they confer only 40% of the degrees earned by Blacks, eighty percent (80%) of Black science doctorates are graduates of Black undergraduate institutions. These facts provide convincing argument for the continued existence of the Historically Black College and also for increased support by the National Institutes of Health and others. As a matter of fact, in the early 1970s, recognizing this valuable resource, NIH and other federal agencies developed programs targeting the Historically Black Colleges. The two most notable and earliest programs emanating from the National Institutes of Health are the MBRS Program and the MARC Program.

The Minority Biomedical Research Support Program is designed specifically to address and ameliorate the underrepresentation of ethnic minorities in biomedical research and research related activities. The major mechanism for doing this is support of activities which increase the participation of Black, Asian American, Hispanic, and Native

American faculty and student degrees and/or careers in the biomedical sciences, specifically biomedical research.

The MBRS Program has had significant impact on minority students, particularly those at the Historically Black Colleges and Universities, resulting in an increase in the production of Ph.D.'s, publishable research, and other mainstream activities. Most significant, is the fact that MBRS research at HBCU's has, to a degree, made HBCU's more competitive for other sources of research funds. While the gains due to the influence of the MBRS Program may not be impressive to some (our critics), keep in mind that the slippage which the program enabled many HBCU's to avoid must be added to the gains directly attributable to the program.

MBRS PROGRAM DESCRIPTIONS

MBRS grants are normally made to two- and four-year colleges, universities and Health Professional Schools where the eligible minority population is at least 50%. Since its inception in 1972 a total of about 7,900 students have participated in the MBRS Program. In FY 1987; 844 faculty and 1,517 students on 798 projects at 100 institutions were supported.

The MBRS Program strategically consists of 3 subprograms.

1. Regular MBRS
2. Undergraduate College Research Participation, and
3. Thematic Grant Awards.

Three other MBRS Program funding mechanisms exist. They include:

1. The Supplemental Award for Shared Equipment
2. An element for supporting minority students participating in research at institutions with less than 50% minority populations
3. The Minority Biomedical Research Support Supplemental Grant for Animal Resource Improvement

The oldest MBRS Program is the Regular MBRS Program which supports an MBRS Director and groups of individual biomedical research projects at each institution. These projects include support for faculty researchers and student research assistants. Such support affords faculty, normally over-burdened with heavy teaching loads, the time to participate in research and to develop research skills. Although students participating on MBRS projects gain valuable hands-on experience, $1,000,000 is needed to raise their salaries to be competitive with other student salaries in NIH Programs. Therefore, it is recommended that MBRS student salaries be increased to become competitive within the NIH mainstream.

The Undergraduate College Research Participation Awards subprogram was developed in 1985 specifically to enhance the research capabilities of two and four year colleges whose missions are primarily to serve minority students. Most, for a myriad of reasons; lack of equipment, facilities and other resources, have not been able to procure research

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The Undergraduate College Research Participation Awards subprogram was developed in 1985 specifically to enhance the research capabilities of two and four year colleges whose missions are primarily to serve minority students. Most, for a myriad of reasons; lack of equipment, facilities and other resources, have not been able to procure research funding from other sources. These awards, which are limited to $150,000 a year in direct costs, support pilot research projects, regular research projects and enrichment activities. Enrichment activities included travel to scientific conferences and so forth.

The Thematic Grant Awards subprogram, which was also created in 1985, is limited to institutions with a 50% minority population and a demonstrated high level of research capability. More specifically, the qualifications for consideration include; granting of the doctoral degree, a significant number of postdoctoral researchers, and facilities which will allow the expansion of biomedical investigations. Thematic awards are limited to $300,000 per year.

Supplemental Awards for Shared Instruments allow institutions to buy research equipment which may cost more than the funds available for a single project. Grants range from $25,000 to $150,000.

Associate Investigators: Minority graduate and undergraduate students are also supported by MBRS at institutions with less than 50% minority student populations. The investigators, on whose projects the student participates, are classified as Associate Investigators, and must have active research programs and grant support. In this subprogram the money is earmarked for the participating students.

The MBRS Supplemental Grant for Animal Resource Improvement Initiative was announced in November of 1986. Up to one million dollars is available in 1987 for funding supplemental grant applications (for no less than 10,000 and no more than 100,000) for the purposes of improving animal facilities, training personnel, and purchasing and related equipment. This special initiative will enable eligible MBRS grantees to comply with PHS policies on the care and treatment of animals and with the USDA Animal Welfare Act.

A NEW PROGRAM PROPOSAL: A HIGH SCHOOL INITIATIVE

Rationale:

- There is a steady decline in the number of Ph.D.'s awarded to Blacks who are U.S. Citizens (1116 in 1977 and 820 in 1986).
- A decline in the number of Ph.D.'s awarded to Hispanic males (U.S. citizens) is also surfacing. After an increase to 344 in 1982, the numbers reported for 85 and 86 are 300 and 299, respectively.
- Statistics for college-bound minority students show alarming trends:
    - The total college age population is on the decline.
    - There is a projected large increase in the number of Black and Hispanic high school graduates.
    - There is a steady (and increasing) decline in the proportion of Black and Hispanic high school graduates entering college.

Approach and Activities of the Proposed High School Initiative

An approach that can be used by the MBRS Program is an expansion and extension of the very successful enrichment element of the undergraduate college initiative. This will reach out to the pre-college minority students and address the preparation and motivation of these students for a science career choice. These students are still in a position to make choices in their academic preparation that will allow them to be competitive for science careers when they enter college. This requires outreach program activities to reach the masses of students, not the current methods of selecting small numbers of students to place in laboratories. Reaching parents, teachers and school administrators and involving them in the process.

Activities to be supported could include:

(1). Visits to laboratories by high school students

(2). Summer Workshops - laboratory methods, mathematics, communication skills, motivation to prepare for and enter the sciences, college preparation, financial assistance, and attending science meetings

(3). Parent and teacher workshops and outreach by the colleges and their MBRS student role models.

Budget for New Initiative

For all of the above efforts, it is obvious that substantial additional funds and staffing will be required:

1989 - $2 million plus two staff
1990 - $4 million one additional staff

(over 100 eligible institutions / $100,000 - $200,000 per year)

IMPACT AND OUTCOMES OF THE MBRS PROGRAM

Collaboration with most NIH Institutes, Alcohol, Drug Abuse, and Mental Health Administration, and other sponsors of biomedical research constitutes a significant aspect of the MBRS Program. These sponsors co-fund and monitor, with MBRS, projects at MBRS institutions. From 1975, when co-funding started, to 1986, co-funding arrangements increased from nine (9) to two hundred thirty three (233) projects.

Faculty and Student Development

Of the 13,000 undergraduate students who have participated in the MBRS Program since its inception in 1972, 8,000 have received bachelor's degrees, 256 have received Ph.D. degrees, 800 have received medical degrees and almost 100 have received dental degrees. Six hundred and thirty three (633) are currently enrolled in medical or dental schools.

About 1500 MBRS students attended scientific meetings and conferences in 1986. Many co-authored papers and presented their research at these meetings.

A number of former MBRS participants who have earned graduate and professional degrees have returned to predominantly minority institutions as faculty members.

Those faculty who serve as investigators on research projects are attending more science symposia, publishing more research papers, and have lighter teaching loads than their non-MBRS colleagues.

Institutional Development

In 1972, 170 research projects were sponsored at 38 institutions. IN 1986, 798 researcher projects were supported at 100 institutions and investigations ranged from hypertension studies to efforts requiring Recombinant DNA Technology. The benefits to MBRS institutions were enormous. These schools:

1. attracted more research-capable faculty
2. improved research and instructional resources
3. recruited better students.

It is estimated that more than 850 projects at 125 institutions will be supported in 1989 with a projected budget need of $42 million.

CONCERNS REGARDING THE MBRS PROGRAM

Of great concern is that despite the fact that the MBRS and MARC Programs have had significant impact on biomedical research at the HBCU's, the current faculties have not been able to significantly break into that fraternity called "regular review," or "R01." The reasons are two-fold. Most prohibiting is the fact that it is a closed fraternity; secondly, not enough earmarked money has been invested in meaningful research projects at HBCU's.

Also of great concern is that the evidence seems to indicate that though the MBRS and MARC Programs were created with HBCU's in mind, the recent focus of the MBRS Program is toward non-Black minorities. This apparent shift in emphasis is at the expense of funding for Blacks at the Historically Black Colleges and Universities. Increasingly, projects and programs are being phased out, especially the HBCU's; and are increasingly being established at other institutions, including majority universities such as: the University of California at San Diego, which receives over a hundred million dollars in federal funds; Hunter College in New York and others. While it is arguable that minorities at any institution should be supported, many of the majority institutions have resources and facilities far more significant than those of the HBCU's. Moreover, Blacks and the HBCU's have been historically the most neglected of people and institutions, despite the fact that some of the institutions were created to enable or perpetuate the exclusion of Blacks from such colleges and universities.

Among the other concerns of the Directors and investigators at MBRS-supported institutions is the fact that too many investigators who have "released" time salary are released but not "replaced". Because MBRS grant provisions only require that supported individuals be relieved of some responsibility to do research, some institutions resort to upping course load requirements, changing titles, not giving credit for previously credited activities, etc. Therefore, it is the recommendation of MBRS directors and investigators that MBRS require that MBRS directors and investigators be replaced for that percentage of time they devote to their respective projects.

AIDS RESEARCH

Just as with the six factors identified in Secretary Heckler's Task Force report on Acquired Immune Deficiency Syndrome, AIDS, as it is commonly referred, is another disease which disproportionately affects Blacks and other minorities as compared to the U.S. population as a whole. According to the Centers for Disease Control in Atlanta, Georgia, of the 25,000 cases of AIDS reported to them through September 8, 1986, 25 percent were Black and 14 percent were Hispanic; these groups represent only 12 and 6 percent, respectively, of the U.S. population. These figures are even higher for Black and Hispanic women. This disease, AIDS, is now a major public health problem.

In order to address this problem funds should be allocated for support for investigator initiated studies in a number of basic science areas including immunology, virology, and development and cellular neurobiology; improved containment facilities; construction and renovation funds; equipment; social science and behavioral science research; and epidemiological studies. There is $50,418,000 in the FY88

DRR budget for AIDS research and $38,000,000 has been targeted in the FY89 budget -- none of which has been allocated to the MBRS Program. It is recommended that at least $2,000,000 of these funds each year be reappropriated to the MBRS Program so that AIDS research will then be implemented in all programs supported at NIH.

MBRS BUDGET - FY 1988

APPROPRIATION	28,252,000
CO-FUNDING - DRR (GCRC)	11,432,250
TOTAL FY 1988 BUDGET FOR MBRS	39,684,250

COMMITMENT BASE OF ON-GOING GRANTS

GRANTS AWARDED (99)	48,030,178
UNDER REVIEW	189,512
ANIMAL RESOURCES INITIATIVE	1,000,000
TOTALS	49,219,690
TOTAL DOLLARS AVAILABLE	42,684,250
SHORT-FALL	6,535,440

SUMMARY OF PRESENT BUDGET NEEDS

**	FY 1986 COMMITMENT SHORT-FALL	$ 6,535,440
**	AIDS RESEARCH	2,000,000
**	INCREASE FOR MBRS STUDENT SALARIES	1,000,000
**	PROPOSED HIGH SCHOOL INITIATIVE	2,000,000
	TOTAL	$11,535,440

SHORTFALLS

Shortfalls in FY88 and for FY89 are exacerbated by: (1) having no additional funds for the salary increases for students (implemented in FY 1987); (2) this resulted in termination of Instrumentation Program in FY88; (3) furthermore, many institutions are just now catching up on overdue faculty salary increases and there is no inflationary (cost of living) increases in the FY89 budget.

The shortfall of 13% in FY89 is expected to be increased in FY89 due to the latter, resulting in necessity to phase out or terminate several institutions where further reductions would not leave enough of a program to be cost effective/worthwhile.

Senator CHILES. Thank you, Doctor.

I'm not sure that there aren't a few programs. The point that you make is very, very good. There may be a few programs that you don't know about. I would like to make sure that you do know about them because in the work that you are doing, there may be something that you can touch on there.

There are minority business support grants out of NIH at the amount of $38 million, and there are some training programs, too.

If we could just have you in a session with staff, I would like for you to be able to get that information.

Dr. JOHNSON. Thank you very much, sir.

Senator CHILES. Thank you, sir.

STATEMENT OF MORDECAI P. BLAUSTEIN, M.D., CHAIRMAN, DEPARTMENT OF PHYSIOLOGY, AND HEAD, HYPERTENSION CENTER, UNIVERSITY OF MARYLAND, BALTIMORE, MD, IN BEHALF OF THE BIOPHYSICAL SOCIETY

Senator CHILES. Now we will hear from Dr. Mordecai Blaustein, chairman of the Department of Physiology and Head of the Hypertension Center at the University of Maryland.

Dr. BLAUSTEIN. Mr. Chairman, I thank you for the opportunity to testify on the fiscal year 1989 NIH budget, on behalf of more than 5,000 scientists in the Biophysical Society.

I am Mordecai Blaustein, chairman of the Department of Physiology and Scientific Director of the Hypertension Center at the University of Maryland at Baltimore, and a member of the Biophysical Society.

First, my colleagues and I thank you for your past support of the NIH, which has led to enormous advances in biomedical knowledge. We are especially grateful for the recent support of funds for graduate education in biophysics.

I would like to make two points. One concerns support for training. The second concerns research grants.

I am director of a new NIH-funded training program, and I assure you that one of our highest priorities is to educate the next generation of biomedical scientists. But we have a manpower crisis.

In 1972, NIGMS supported 4,042 predoctoral trainees. This year, there are only funds for 1,717.

Our own program supports a total of five trainees for the 5-year curriculum. That is only one trainee per year.

Because of the shortage of funding, we are losing the most capable college graduates to other fields, and only with more capable thinkers will we be able to make more breakthroughs.

As La Rochfoucauld said, although men flatter themselves with their great actions, they are not so often the result of design as of chance, and chance, said Pasteur, favors the prepared mind.

My second point concerns the inadequate number of individual investigator-initiated research grants and the erosion of funds due to administrative cuts, called downward negotiations.

I myself received a 10-percent cut in an NIH grant this year, and that is 10 percent below the peer review recommendation to enable me to carry out the research.

Now, the importance of nontargeted investigator-initiated research grants is illustrated by my own experience.

Starting with basic research on nerve and muscles of marine invertebrates, my colleagues and I unexpectedly discovered a relationship between sodium and calcium metabolism, and this led me to develop what is today the most quoted theory about how excess dietary salt leads to high blood pressure.

This, in turn, led to the discovery of a new hormone that may be the critical link between salt and high blood pressure. One of my colleagues at Maryland has just purified this hormone, but he has two competitors, and both are Japanese.

The race is now on to determine the structure of this hormone and, given the NIH support that led to the initial breakthroughs, we certainly intend that any patent rights that issue from this research will be issued first in the United States.

Incidentally, the colleague who made this breakthrough is an Englishman, who came here to work because of inadequate funding in Great Britain.

We cannot permit that to happen in the United States.

Therefore, we join with the ad hoc committee for medical research funding in recommending a fiscal year 1989 appropriation of $8.2 billion for NIH, including AIDS funding. That will support about 7,400 new and competing and continuation research grants, as well as the 11,000 trainees recommended by the Institute of Medicine.

Only with a cadre of well-trained scientists and an adequate knowledge base can we be prepared to tackle critical problems of our age, including the current AIDS crisis.

PREPARED STATEMENT

Senator Chiles, we thank you very much for your strong support of the NIH over the years, and certainly we regret that you will not be here next year, so that we can continue to work with you to follow up on these strong efforts.

[The statement follows:]

STATEMENT OF MORDECAI P. BLAUSTEIN

I am Mordecai Blaustein, Professor and Chairman of the Physiology Department and Scientific Director of the Hypertension Center at the University of Maryland at Baltimore. I am here today representing the membership of the Biophysical Society-- over 5,000 men and women scientists, whose research, scholarly and academic activities are deeply affected by the decisions this Subcommittee makes regarding the budget for the National Institutes of Health.

Over the years, the Members of this Subcommittee have shown time and again, their unfailing commitment to health and basic research. Indeed, it has been your vision and your support for the National Institutes of Health that have made NIH and our biomedical research infrastructure a model for the rest of the world.

Mr. Chairman, as working scientists we deeply appreciate all your Committee's efforts on behalf of NIH. The decisions you are faced with are, indeed, difficult, particularly in light of the fiscal pressures our country is experiencing. We fully understand that federal dollars are extremely tight, and that this Subcommittee, and the Congress as a whole, have many pressing and deserving needs.

Nevertheless, we would be remiss as scientists, and as concerned citizens, if we did not come to you to express our views and to join our voices with those present today who believe that it is imperative to increase the NIH budget in order to maintain the excellence for which it is noted.

While writing this testimony it was rather difficult, I must confess, to think of arguments which you may not have heard or may not have used yourself in support of NIH and the extramural programs. All of these arguments are as valid today as they were the first time they were made - the importance of patient care, new cures for diseases, exciting new research with biomedical applications, etc. After giving it some thought, I decided that perhaps the best contribution I could make was to share with you my own experiences and my own concerns as I am sure these will reflect, in many ways, the experiences of my colleagues.

There are two areas I would like to mention specifically: the need for enhanced training support, and the need for a growing individual investigator-initiated grant program.

Training is, in our view, one of the most important and critical investments our country can make in its future. The Biophysical Society membership, for example, was delighted to learn that the NIH recently established a much needed and welcomed training program in the biophysical sciences. This training program has opened new career opportunities that will enable us to make this field so much more attractive to potential scientists. The positive impact of such a program will be measured not only by the enhanced student enrollments, but also by the positive impact such a program has on the principal investigators themselves.

As welcome as this new program is, however, the need for additional training funds in the biomedical sciences is still tremendous. The lack of appropriate resources in these areas is seriously curtailing our ability to attract bright new students and is directly affecting our ability to carry out new research projects. Let me give you an example. Last year, the School of Medicine at the University of Maryland successfully competed for a training grant in the area of membrane biology. This grant, in which 7 basic science departments and over 25 investigators participate, allows us to support 5 new pre-doctoral students. As Program Director, I can assure you that this support has proven invaluable for attracting top quality students and has given the involved faculty new expectations and excitement. It is quite obvious, however, that 5 students for over 25 investigators is a very inadequate ratio as a number of extremely qualified investigators, who put time and effort in developing this proposal, will not directly reap the benefit of this award. Moreover, since the training takes 4 to 5 years, we have sufficient support to graduate only about one student per year.

At the national level, matters are even more bleak. Other deserving Universities and research groups have seen the support for pre-doctoral students continuously eroding. In the particular instance cited above, only two new training program awards were made nationwide. Clearly, a field as wide open as membrane biology cannot sustain itself with only a handful of new Ph.D's.

Mr. Chairman, I respectfully request that training be given a very high priority in the FY89 NIH budget and that funds for 11,340 pre- and post-doctoral trainees be included, as recommended by the Institute of Medicine. It is also imperative that the level of the pre- and post-doctoral stipends allowable under NIH guidelines be increased to make these positions competitive with other positions nationally and appealing, once more, to our students.

The second issue pertains to the need to enhance the pool of individual investigator-initiated awards. As you are well aware, revolutionary scientific discoveries seldom come in a predictable and orderly fashion. They are, in most cases, the result of ingenuity, creativity, luck and a good measure of hard work. Time and again, we read about the investigator who "stumbled" onto the magic ingredient for the cure of an ailment, or the researcher who, while working on one project opened up an exciting new field in a seemingly unrelated area. The examples abound: from penicillin to chemotherapy for testicular cancer, from the development of tissue culture methods (required for growth of viruses) to the accidental discovery by the 1986 Nobel laureates in Medicine, that snake venom is a potent source of nerve growth factors.

Indeed, I can attest to this first hand. As an NIH-supported postdoctoral fellow researching sodium metabolism in squid nerve, I unexpectedly discovered a critical link between sodium and calcium metabolism. I was not then working in the hypertension field, but pursuit of these exciting results eventually led me to the development of what is today the most widely quoted theory about how excess dietary salt causes high blood pressure. I did not set up to look for this link, nor did I expect these results; however, the ability and flexibility to continue the research in this direction proved to be of direct benefit to the biomedical community.

Mr. Chairman, supporting investigators to carry out independent and innovative research projects is critical if we are to maintain a world leadership position in the biomedical field. I, therefore, respectfully request that the FY89 NIH budget provide for 7,400 new and competing grants. This number of awards, the proposed number of training positions, the biomedical research support grants program, cooperative clinical research, minority biomedical research support and the NIH intramural program will require a substantial increase in the NIH FY89 budget. We join with the Ad Hoc Group for Medical Funding in recommending a FY89 appropriation of $8.2 billion (including AIDS funding).

Finally, Mr. Chairman, I would like to bring to your attention an issue which concerns us greatly: the "downward negotiations" on research grants. By NIH's own admission, budget cuts on new grants and competitive renewals are averaging 11% and over 7% for non-competing continuations. These cuts are severely eroding our research infrastructure and are creating havoc within our laboratories. Indeed, if the President's budget is honored, these cuts could be as high as 13% in FY89. These arbitrary, non-scientific cuts must be curtailed if biomedical research in our country is to continue.

Mr. Chairman, thank you again for this opportunity to share our views with you. The funds you will appropriate are part of the public trust and I firmly believe the public supports our efforts to enhance the quality of life through research. Thank you.

Senator CHILES. I thank you very much.

I look forward to getting a little of that hormone or whatever it is. I have given up salt, or tried to for a period of time, but you find it in so many products, other than the water you drink, and you sometimes worry about the sodium in that. It is very hard to get away from salt, no matter how you try.

Dr. BLAUSTEIN. We think it is very difficult, too, and we certainly hope that once we find out about all of the intermediate interactions that eventually lead to high blood pressure, we can perhaps begin to change our habits a little bit.

Thank you.

Senator CHILES. Thank you.

STATEMENT OF TIMOTHY R. TALBOT, JR., M.D., FORMER PRESIDENT AND CHAIRMAN OF THE BOARD, ASSOCIATION OF AMERICAN CANCER INSTITUTES, AND PRESIDENT EMERITUS, FOX CHASE CANCER CENTER, PHILADELPHIA, PA

Senator CHILES. Now we will hear from Dr. Timothy Talbot of the Association of American Cancer Institutes.

Dr. TALBOT. Mr. Chairman, the testimony that I have just handed to you for the record is that from Karen Altman. I have been asked to pass along to you.

I am Timothy Talbot, former president and chairman of the Board of the Association of American Cancer Institutes and president emeritus of the Fox Chase Cancer Center in Philadelphia.

The message that I wish to bring to your attention is that the cancer center core grant program of the NCI is in serious trouble.

That program has been chronically under-funded for several years in relation to other NCI programs. It has also lost ground in terms of constant dollars, at a time when pressures are extremely intense to increase and improve the cancer center's programs.

We are very grateful to you, Mr. Chairman, and to the members of this committee, and to many others, for providing last year in your bill, report language providing $118 million for cancer centers, which was the bypass budget level.

The House committee earlier provided $103 million, and I understand you and they were considering in negotiations splitting the difference, which would have provided $110 million.

However, in the deficit reduction negotiations, NIH programs received the split difference level, less the 4 percent. At that time we thought the cancer centers would receive $106 million. However, after the OMB got through, only $100.6 million was left for the cancer centers' programs.

And now, the President's proposed budget has straight-lined that level for fiscal year 1989.

The impact of that would be devastating, and would result in a decrease of 30 percent for peer reviewed levels of competitive grants for the centers.

As that great and effective man, Dr. Jim Shannon, said long ago, the reason for the existence of the NIH is to establish and preserve the science base of our national biomedical enterprise. If the infrastructure of these efforts is allowed to deteriorate, then there is little that we can expect in the future.

The cancer centers play a crucial role in these efforts.

We wish also to endorse and support Senator Kennedy's bill, which, as you know, has been supported by Senator Weicker.

PREPARED STATEMENT

We call to your attention the figure of $135 million requested in the bypass budget of the NCI. This is a minimum, realistic budget. We sincerely hope that you and your committee will consider these concerns, and we thank you for your attention and consistent support of these nationally important issues.

I will be pleased to answer any questions that you wish, sir.

[The statement follows:]

STATEMENT OF TIMOTHY R. TALBOT, JR.

Mr. Chairman and Members of the Committee, I deeply appreciate the opportunity to appear before you to present the concerns of the Association of American Cancer Institutes (AACI), which includes all the major cancer centers in the nation.

I am Dr. Timothy R. Talbot, Jr., former President and Chairman of the Board of the AACI, and President Emeritus of the Fox Chase Cancer Center in Philadelphia, Pennsylvania.

The cancer centers core grant program of the National Cancer Institute is in serious trouble.

Last year we presented to you data which indicated that the cancer centers budget levels had increased between fiscal year '83 and fiscal year '87 by only 19%, while the NCI itself was increasing by 45%, and the N.I.H. as a whole by 50%.

We also presented documentation showing that there has been a drop-off of 10% in terms of constant dollars between 1980-1987 for the Cancer Centers Program.

President's Proposed Budget

As you know, Mr. Chairman, the President's proposed budget indicates that the cancer centers budget item should be "straightlined" for fiscal year 1989 from last year's level. That level, in precise terms, was $100.6 million. The impact of that level of funding would be devastating.

When Dr. DeVita, Director of the National Cancer Institute appeared before the House subcommittee several weeks ago, in answer to a question asked by Representative Joseph Early regarding cancer centers, it was indicated that competing cancer center grants would be reduced from recommended peer reviewed levels by approximately 30%, if the President's proposed budget was agreed to.

Last Year's Actions

Permit me to review last year's appropriations actions to show how this potentially disastrous situation has occurred.

You will recall that you and your committee made a major effort to increase funding for cancer centers last year, and for that we are profoundly grateful. Specifically, in your Senate bill report accompanying the Senate appropriations bill, it was indicated that "The Committee has included $118 million for the centers program." That was the amount that had been requested in the By-Pass Budget in order to provide appropriately for the centers program; that was the amount requested by the AACI in our testimony. The reported House appropriations bill would have increased funding levels from approximately $94 million to the level of $103 million, about a $10 million increase. This would have gone a long way to helping salvage a difficult situation.

However, after the stock market "crash" in October and the necessary budget deficit activity by the Congress, and subsequent Office of Management and Budget negotiations with the National Institutes of Health and the National Cancer Institute final budgeted figure was $100.6 million for the Cancer Centers Program.

The difficulties presented by that low level of funding have been compounded this year because the Administration has proposed that all centers programs in the National Institutes of Health be "straightlined" at the fiscal year 1988 level.

Current Situation

The pressure on the cancer centers of this country is greater than ever before. This problem has been further accentuated by the fact that the NCI By-Pass Budget has proposed a 50% increase in the number of centers by 1992. The NCI also proposed in that budget that there be 10 new centers in fiscal year 1989 to facilitate the conduct of cancer control activity in selected regions. If that happens without an increase in funding the result will be the partial destruction of what is already functioning at a high quality level in existing centers. As that great and effective man Jim Shannon said long ago, the reason for the existence of the NIH is to establish and preserve the science base of our national biomedical enterprise. If we lose that, or diminish it, we will have lost it all for the future.

Summary

Mr. Chairman, the Cancer Centers Program of the National Cancer Institute, developed with such great congressional support after the passage of the National Cancer Act in 1971, is now very seriously threatened. An essential part of the infrastructure of cancer research is now beginning to crumble. The Congress, time and time again, has supported the concept of the Cancer Centers Program; your support for the concept has never lessened.

We call to your attention the figure of $136.6 million requested in the By-Pass Budget for cancer centers.

We sincerely hope you will consider these concerns when your committee deliberates on these matters.

Senator CHILES. I thank you, Doctor.

There is no way that we can approach those figures, given the allocation that we now find ourselves with. This subcommittee ends up with less money set aside by the Appropriations Committee than the President had in his budget for the entire areas of health, education, and labor. It is a tragic situation that we find ourselves in. But that is where we are right now.

I know of the fine work that the centers do.

I think the centers are going to have to raise the additional funds on their own, and NIH itself is not going to get the kind of funding that they would like as well, given where we find ourselves in this budget cycle.

Dr. TALBOT. We are aware of that sad story, but let's keep trying. Thank you, sir.

Senator CHILES. Thank you.

STATEMENT OF THEODORE C. MARRS, M.D., MEMBER, NATIONAL BOARD OF DIRECTORS, AMERICAN CANCER SOCIETY

Senator **Chiles**. Now we will hear from Dr. Theodore Marrs of the American Cancer Society.

Dr. **Marrs**. Senator, each year the American Cancer Society recommends to the Congress a citizens budget figure for the National Cancer Institute for the coming year.

Members of the American Cancer Society Board have reviewed the NCI proposed budget for fiscal year 1989 and endorsed the funding at the $2.08 billion level, fully recognizing, of course, the problem of the squirrel's cage that you pointed out to us earlier.

We represent the private sector.

Now, more than 2 million volunteers serve the people of this Nation in every State, at no cost to the Government. Support of cancer research is one of our major objectives. From our funds, we provide nearly $100 million in support of investigator-initiated, peer reviewed research.

We feel that our experience and that expertise in the field of cancer uniquely qualify the society to serve as a nongovernmental authority in this area.

The administration's scientific advisors agree with us that the time has come for a major infusion of funding. Research, both clinical and basic, remains the key element to progress against cancer. We believe that the most compelling argument for the higher funding is the urgent need to currently increase the percentage of approved research grants from the level of 37 percent, which is rather tragic, because we lose a tremendous number of highly probable, effective research projects.

We recommend that the funding of approved grants be increased to a minimum of 50 percent, which would be possible at the funding level that we propose.

Also, we strongly support the NCI's control and prevention initiatives. While similar to those of the American Cancer Society, we believe that they are complementary, and deserve the highest possible level of support.

As to the construction needs which are referenced in the budget, I have recently visited the antiquated and inadequate facilities which would turn many otherwise motivated young researchers away.

Finally, as a former Air Force officer, I would like to make two quite relevant points.

In fiscal year 1989, cancer will kill over 490,000 Americans. Compared with the death toll in Vietnam, this is a stupendous and overwhelming figure. The $2.08 billion budget that we support for cancer in fiscal year 1989 would be a drop in the bucket, compared with what you, the President and the Congress would provide if a foreign enemy killed 490,000 persons in 1 year.

Senator, I don't know whether it has any particular meaning or exactly what that meaning is, but in the hall outside the room here, I found a loose screw, which possibly came out of the squirrel cage. I don't know with whom I should deposit it. But I will leave it with the guard out front, unless you need it.

Senator **Chiles**. Some screws have been coming out of that cage, recently. [Laughter.]

PREPARED STATEMENT

Dr. **Marrs**. I hope you enjoy as productive a life in departing from here as you have had here.

Thank you.

Senator **Chiles**. Thank you very much for your testimony.

[The statement follows:]

STATEMENT OF THEODORE C. MARRS

Mr. Chairman and members of the Committee. I am pleased to be here today to present the "Citizen's Budget" for FY '89 for the National Cancer Institute on behalf of the American Cancer Society, the world's largest voluntary health agency--over 2 million active volunteers.

I am Dr. Theodore Marrs from Albuquerque, New Mexico. I am a member of the National Board of Directors of the American Cancer Society. I am a member of the National Public Issues Committee and National Public Issues Executive Committee. I am a former Assistant Secretary of Defense for Reserve Affairs and former Assistant to the President.

Mr. Chairman, each year the American Cancer Society (ACS) recommends to the Congress a "Citizen's Budget" figure for the National Cancer Institute for the coming fiscal year. Traditionally, this figure has represented the best judgement of the Society regarding that portion of our country's national resources which we believe our government should dedicate to the battle against cancer. Characteristically, the Society's figure has been considerably higher than that recommended by the President in his annual budget message. While the Society's annual recommendation has been higher, it has in every instance, represented the Society's attempt to be practical and responsible, and at the same time, be realistic concerning the amount of funding necessary to fight cancer during the year.

Mr. Chairman, the American Cancer Society has come before House and Senate appropriations subcommittees for nearly 40 years to speak on behalf of the American people about the National Cancer Institute appropriation. We come before you because we represent the non-government, private sector. Our more than two million volunteers serve the people of this nation in every state, county and community, at no cost to the government. Support of cancer research is one of our major activities. In 1987, ACS provided nearly $100 million in support of investigator-initiated peer reviewed research. Additionally, we allocated over $62 million of our voluntarily donated funds to public education; over $63 million to patient and community services; and almost $34 million to professional education. The Society is the largest single source of private, non-commercial funding for cancer research and control. We feel that our organization, experience, and expertise in the field of cancer uniquely qualify the Society to serve as the non-government authority in this area.

In 1987, President of the American Cancer Society, Dr. Virgil Loeb, presented the Society's recommendation of the 1988 appropriation of $1.5 billion exclusive of AIDS funding. NCI's 1988 appropriation came very close to that figure - $1,469,327,000, which included $80 million for AIDS funding. We were disappointed that our 1988 figure of $1.5 billion which we urged be exclusive of AIDS funding was not met.

The American Cancer Society applauds and congratulates the Congress, and particularly, the members of this subcommittee, for their leadership, foresight, and sensitivity to the continuing importance of cancer research and control through realistic appropriations for the NCI.

But the battle against cancer has reached a crucial stage. While appropriations have been increasing in recent years, they have not been able to keep up with the potential, increasing momentum in cancer research progress.

Mr. Chairman, the American Cancer Society believes that FY '89 will be the year of dramatic, significant advances against cancer. Because of this, we are recommending a Citizen's Budget of $2.080 billion for NCI for FY '89. This figure represents a significant increase over the size of increases the Society traditionally recommends, but we believe it is fully justified, and realistic considering the opportunities and the potential. Also, we believe it is a small investment promising giant returns in the cancer battle which is costing the federal treasury more than $65 billion each year in lost wages, productivity, lost tax revenue and human suffering. We hope that as a result of the practicality and prudence of our previous Citizen's Budget recommendations, you will give our new and increased figure the respect and consideration you have given our recommendations in previous years. It is a real figure, and I firmly believe that if you appropriate this amount of money in FY '89, the money would be well spent.

For the record, I want to reiterate, as my predecessors have when they have had the privilege of appearing before this committee, that the American Cancer Society receives none of the funding we are requesting for NCI. The Society has a firm policy of not accepting government money.

Our figure of $2.080 billion represents a decision reached as a result of thorough review of the needs, opportunities, and objectives in cancer research today. Our figure happens to be identical to the NCI Director's FY '89 "by-pass" budget, developed by Dr. DeVita and his staff. They have assembled a well balanced, practical budget.

The President's FY '89 budget for NCI totals $1.597 billion. By traditional White House standards, this represents a very impressive increase over the previous year. It is almost 9%, and in recent years it has usually been status quo, or at best a small, token increase. Our system works, however, because Congress always has brought the appropriation figure up near where it should be, and the President signs it into law.

We like to believe that the President's advisors agree with us that the time has come for a major infusion of funding. We all have our sights set on the Year 2000 as the target for a massive reduction in cancer incidence and mortality. We believe that target is realistically attainable if adequate resources are allocated and applied.

Research, both basic and clinical remain the key element in progress against cancer. We believe that the most compelling argument for higher funding is the urgent need to increase the percentage of approved research grants. Approval of these grants is based on peer review. By approving them, their scientific peers determine that they are vitally needed to add knowledge to our search for better understanding of the mysteries of cancer.

There are a tremendous number of good, important ideas that are not being followed up. It is difficult for a group of scientists, reviewing research applications, to predict where the best ideas will come from. The clue to the critical information which might move us quantum leaps ahead could be overlooked among the grants we have not had the money to fund. We recommend that the funding of approved grants be increased to a minimum of 50%.

Even now, ideas are exploding in the basic cell biology of cancer and its mechanisms. We are learning about oncogenes, their cancer causing expressions and how they control cell behavior.

Recent research has brought us closer to understanding chromosonal abnormalities. In one significant case, it has been demonstrated that deletion of a repressor gene from a chromosome is a necessary step in the function and activation of an oncogene. Further developments like this in cell biology reached through research will lead to our ability to control cancer. Advances in understanding the way cells develop resistance to drugs would significantly improve the effectiveness of chemotherapy. Development of new applications of known, effective drugs would broadly expand our treatment resources.

The development of man's ability through modern biotechnology, to produce large quantities of identical substances such as biological response modifiers, or drugs that have been in sparse supply, has significantly improved the potential for effective cancer therapy.

As important as improvements in the diagnosis and treatment of cancer are, prevention is still the best human cancer fighting technique. A prevented cancer never has to be treated. Very exciting strides forward and being taken by the American Cancer Society, and the National Cancer Institute. The use of tobacco is at a modern-day low. Many lives will be saved, and people will live longer as a result.

We strongly support the NCI's Control and Prevention initiatives. While similar to those of the ACS, we believe they are complimentary. They deserve the highest possible levels of support.

A budget of $2.080 billion would also assure a vitally needed infusion of funds for construction. Mr. Chairman, the cancer research infrastructure is deteriorating rapidly. There has been no meaningful construction money for years. In 1984-1985, the American Cancer Society, in collaboration with Dr. Armand Hammer, conducted a survey of construction needs in cancer research. The results were surprising then; alarming today. I would like to quote a few excerpts from the Executive Summary of that three year old report.

> "The study's findings indicate crowding in basic research laboratories and a need for additional space in all areas of

cancer research - basic, clinical, animal, and administrative - by 1990. The findings about quality of space (age and condition) indicate that a significant amount of cancer research space is inadequate. If improvements are not made and additional space is not acquired, the National Cancer Program will be hindered by its inability to expand current research, and to develop new programs to meet its Year 2000 goals."

We strongly urge the higher funding to include at least $48 million for research facility construction and renovations, together with the appropriate authorities to spend those funds.

Mr. Chairman, we believe the national goals of reducing the mortality rate from cancer by 25%-50% by the Year 2000 is realistic, and that we are moving ahead on schedule. We will certainly reach this goal if those involved in the battle against cancer are given the tools. Thank you.

I would be pleased to respond to any questions from the Committee.

STATEMENT OF JOSEPH E. CRAFT, AMERICAN FEDERATION FOR CLINICAL RESEARCH, ASSOCIATE EDITOR, AFCR JOURNAL, CLINICAL RESEARCH, AND ASSISTANT PROFESSOR OF MEDICINE, YALE UNIVERSITY SCHOOL OF MEDICINE

Senator **WEICKER** [presiding]. Our next witness is Dr. Joseph Craft, representing the American Federation for Clinical Research.

Dr. Craft, it is a pleasure to have you with us.

Dr. **CRAFT**. Thank you, Senator.

My name is Joe Craft, and I am an assistant professor of medicine at the Yale University School of Medicine.

My research focuses on the study of diseases of the immune system, including Lyme disease and systemic lupus erythematosis.

I am a member of the National Council of the American Federation for Clinical Research and associate editor of that organization's journal, Clinical Research.

I am here today to present the AFCR's views regarding fiscal year 1989 funding for the National Institutes of Health.

The AFCR, the Nation's largest organization of medical investigators, is comprised of more than 13,000 physician and nonphysician scientists, who are engaged in virtually every area of medical research. The programs of the NIH are of special importance to the AFCR membership because most of our members are based in universities and receive funding for their research from the NIH extramural program.

Mr. Chairman, I would like to initially express the AFCR's appreciation, particularly to you, as well as to other members of the subcommittee, for your leadership in advocating adequate Federal funding for biomedical research.

Each year since 1981, we have been disappointed by the administration's lack of commitment to health science, and each year, we have been encouraged, as congressional support for our efforts has remained strong.

The AFCR supports the proposal of the ad hoc group for medical research funding, recommending a fiscal year 1989 NIH budget of $8.2 billion.

This $1.5 billion increase may seem unrealistic, given the need to reduce the Federal deficit. Our organization considers such an increase quite reasonable, however, when viewed in the context of overall Federal research spending.

We believe that a government that can afford a $40 billion budget for military research should be able to spend at least one-fifth of that amount, the requested $8.2 billion, on medical science to improve health care.

I would emphasize that the $1.5 billion increase that we are requesting for the NIH represents less than 4 percent of this year's military research budget.

The AFCR recognizes that this subcommittee does not have authority over all Federal science programs. We hope that you will work with your colleagues on the Budget and Appropriations Committees to reestablish a more appropriate distribution of Federal research dollars in the future.

With a budget of $8.2 billion, the NIH would be able to support 7,400 investigator-initiated grants, which is only 41 percent of the number projected to be approved for funding.

The NIH also would be able to fund grants at study section recommended levels, and avoid the current across-the-board reductions, cuts as high as 12 percent, that are compromising the quality of science funded by the agency.

Unfortunately, even with the $8.2 billion NIH budget, 59 percent of grants approved by peer review study sections would still go unfunded.

Of special importance to the AFCR, the ad hoc group's proposed budget would allow support for 11,300 trainees at increased stipend levels recommended by the NIH.

The stipend increase proposed by the NIH would be the first since 1984, and simply bring trainee stipends in line with the average pay for medical interns and residents.

Currently, a medical resident receives a 5-percent to 9-percent reduction in pay if he or she elects to train for a career in research at the end of the residency. This pay cut prevents many young physicians, often with families at this stage in their careers, from entering medical research.

To summarize, our organization recommends a fiscal year 1989 NIH budget of $8.2 billion. We believe that this is a reasonable request, in light of opportunities that exist in our field.

PREPARED STATEMENT

Further, we suggest that if Federal research priorities are realigned, funding at this level can be accomplished without exacerbating Federal deficit spending.

Thank you.

[The statement follows:]

STATEMENT OF JOSEPH E. CRAFT

My name is Joseph Craft and I am an assistant professor of medicine at the Yale University School of Medicine. I am here today representing the American Federation for Clinical Research (AFCR) to express our organization's views regarding FY 1989 funding for the National Institutes of Health (NIH). I am a member of the AFCR National Council and Associate Editor of the organization's journal, Clinical Research.

I am pleased to have this opportunity to comment on funding for the NIH. The AFCR is the nation's largest organization of medical investigators. It is comprised of more than 13,000 physician and non-physician scientists who are engaged in virtually every area of medical research. Active members must be under the age of 41, as the purpose of the organization is the presentation and critical review of the work of young investigators. However, our senior membership includes many distinguished medical scientists--among them, winners of the Nobel Prize in Medicine.

The programs of the National Institutes of Health (NIH) are of special importance to the AFCR membership. Most of our members are based in universities and receive funding for their research from the NIH extramural program. The AFCR's interest in the NIH is focused particularly on funding for: 1) investigator-initiated research project grants; 2) the National Research Service Awards (NRSA) program; 3) career development awards for young investigators, and 4) the General Clinical Research Centers program.

Mr. Chairman, I would like to begin by expressing the AFCR's appreciation to you and to the members of this Subcommittee for your leadership in advocating adequate Federal funding for biomedical research. Each year since 1981, we have been astounded by the Reagan Administration's lack of commitment to health science and each year, we have been encouraged as Congressional support for our efforts has remained strong.

RECOMMENDATION FOR FY 1989

The AFCR supports the proposal of the Ad Hoc Group for Medical Research Funding, which recommends an FY 1989 NIH budget of $8.2 billion. This $1.5 billion increase over the current year may seem unrealistic given the need to reduce the Federal deficit. However, our organization considers such an increase quite reasonable when viewed in the context of the overall Federal research budget.

As shown in Attachment 1, 66% of Federal R&D spending would be allocated to the military under the President's FY 1989 proposal, compared to 49% in FY 1979. The percentage of research and development funding allocated to health would remain constant at 13%. The AFCR believes that the targeting of research funding to the military ignores the public's desire to make health research a high spending priority and serves to limit the growth that health research merits in this most exciting and promising era of its history. Recently, several Members of Congress, including distinguished members of this Subcommittee, have joined our organization in calling for a reallocation of Federal research priorities. They share our view that a government that can afford a $40 billion budget for military research should be able to spend at least one-fifth that amount--the requested $8.2 billion--on medical science to improve health care. I would emphasize that the $1.5 billion increase that we are requesting for the NIH represents less than 4% of this year's military research budget.

We recognize that this Subcommittee does not have authority over all Federal science programs. However, we hope that you will work with your colleagues on the Budget and Appropriations Committees to establish a more appropriate distribution of Federal research dollars in the future. Clearly, increases for health research funding can be accomplished in a manner that will not compromise Congressional deficit reduction efforts.

Investigator-Initiated Awards

With a budget of $8.2 billion, the NIH would be able to support 7,400 investigator-initiated grants--41% of the number projected to be approved for funding. (Unfortunately, this would mean that 59% of grants approved by study sections would go unfunded.) This proposed budget would allow the NIH to fund grants at study-section-recommended levels. The AFCR considers it critically important that steps be taken to avoid the across-the-board cuts that are currently being imposed on NIH grants. The quality of science funded by the NIH is compromised when the agency must cut grants by as much as 12% despite the fact that the costs of biomedical research supplies and equipment continue to increase dramatically.

Research Training

Of special importance to our organization, the Ad Hoc Group's proposed budget would allow the NIH to support 11,340 trainees at increased stipend levels recommended by the NIH and endorsed by the AFCR. The AFCR believes that high priority should be placed on expanding support for research training in order to: 1) increase research trainee stipends, and 2) maintain the number of biomedical research trainees recommended by the National Academy of Sciences.

An NIH committee on training has recommended that trainee stipends be increased between 5 and 15 percent (depending on the year of training). It is important to recognize that:

- this would be the first increase in training stipends since 1984 (in other words, there has been no cost of living adjustment in training stipends for the last four years), and
- this increase would only bring trainee stipends in line with the average pay for medical residents.

The comparison with medical resident stipends is particularly important. Last year, the average pay for a third-year resident was $25,056. The NIH stipend for a fourth-year trainee is $24,000. Therefore, unless an institution was able to supplement its training stipends from other sources, a resident received a 5% REDUCTION in pay if he/she elected to train for a career in research at the end of a three-year residency. At the end of four years of training, the stipend gap was even wider such that a resident took a 9% reduction in pay upon beginning a research traineeship. It is little wonder that it has become increasingly difficult to attract physicians to research careers--particularly when one considers the overwhelming tuition debts of most medical school graduates.

Career Development Awards

NIH career development efforts are of particular importance to the AFCR as an organization of young investigators. Studies have shown that because the competition for investigator-initiated grants is so fierce--for physician researchers in particular--it is not unusual for years to elapse between the completion of research training and the receipt of a first research project grant. NIH career development awards are essential to support the research efforts of newly-trained researchers and to enable them to make the transition to successful careers as investigators. Without such mechanisms of support, many young researchers would be forced by financial necessity to forego research careers.

General Clinical Research Centers

The Ad Hoc Group's proposed budget would provide moderate funding growth for General Clinical Research Centers. GCRC grants support specialized facilities--usually organized as separate units within hospitals--for the conduct of patient-oriented research. Research conducted in these centers is aimed at identifying how basic research discoveries can be applied to improve the care of patients. In addition, the GCRCs offer a first-hand view of the rewards of research careers to medical students training in host institutions.

As documented in numerous studies over the past ten years, our nation's health science efforts are suffering from a decline in the number of physicians pursuing research careers. As outlined above, General Clinical Research Centers grants can play an important role in ameliorating this unfortunate trend.

Conclusion

I am pleased to have this opportunity to present the views of the American Federation for Clinical Research regarding FY 1989 funding for the National Institutes of Health. To summarize, our organization recommends an FY 1989 NIH budget of $8.2 billion in order to maintain the momentum of today's exciting health research effort. We believe that this is a reasonable request in light of the opportunities that exist in our field. Further, we suggest that if Federal research priorities are realligned, funding at this level can be accomplished without exacerbating deficit spending.

Senator **Weicker**. Dr. Craft, thank you very much. Just two very brief questions.

First of all, how is the research on Lyme disease coming along?

Dr. **Craft**. Well, if I could make a brief point, Senator, most of that research has been done in Connecticut, at Yale. And, since 1985, when the disease was first identified, we have identified the cause as well as the cure of this illness.

About 10,000 people in the United States are afflicted with Lyme disease a year. Without treatment, without the research that has been done at Yale and other institutions, about 6,000 of those 10,000 would develop arthritis.

So, what we have done in the space of 13 years, we, the research community, is abrogated potentially 6,000 cases of arthritis per year via this research, research that has been supported by the NIH, research that has only been funded at a level of less than $1 million or so. Yet, we have abrogated 6,000 cases of arthritis a year.

It is money well spent, I believe.

Senator **Weicker**. I noticed in the paper the other day where they are now saying that it is appearing down-State in Greenwich. The Greenwich newspaper had a story on it. We have not normally associated that with the lower part of the State.

Is that correct?

Dr. **Craft**. That's correct. Fairfield County is now very endemic with Lyme disease.

It has spread. People in all eight counties in Connecticut have the illness. The tick that transmits the illness is found in seven of the eight counties, everywhere but Litchfield.

Senator **Weicker**. What steps are taken to eradicate the tick?

Dr. **Craft**. A lot of research is actually being done in New Haven, at the Connecticut Agricultural Experiment Station, as well as at Yale and other places, on a new tick control agent that you can apply to your clothing to stop the tick from attaching. In addition, pesticides are now being used that will actually eradicate the tick in the field without, at least as we now know it, causing adverse effects otherwise.

Senator **Weicker**. I could not agree more with your statement as to the percentage that we spend vis-a-vis research at NIH as compared with what we spend on the military.

I have to confess to you that I find it baffling, you know, what is needed to get this country up in arms over this issue of health, and, more particularly, research.

Obviously, Americans like to be in good health and like the best medical treatment because, God, all we have to do is take a look at the soaring costs of medical care. Somehow I have to get the point across that one of the few real handles on those costs would be an investment in research.

I cannot make this jump, though. This quantum jump is not coming into people's minds. People say a thousand times a day if you don't have your health, you don't have anything. But, boy, that is not the national policy statement.

We say it as individuals, and we are willing to pay anything we can to stay well, to be well, to live. But, somehow, I have to make people believe that if you put that money into research, that could be a real handle on the care costs existing in this country today.

So, you represent a wonderful group and we will do the best that we can for you. It is as perplexing a problem to me as I am sure it is to you.

What also bothers me is that young people, like yourself, and others, like to have the feeling that there is some consistency in the commitment to research. Otherwise, you might just as well go and practice somewhere else and make twice the money that you are making now.

Dr. **Craft**. That is exactly right.

Senator **Weicker**. Thank you very much.

Dr. **Craft**. Thank you for your support, Senator Weicker.

STATEMENT OF JACK WHITEHEAD, FOUNDER, WHITEHEAD INSTITUTE FOR BIOMEDICAL RESEARCH, AND FOUNDER AND MEMBER OF THE BOARD, NATIONAL LIBRARY OF MEDICINE

Senator **Weicker**. Next we have Mr. Jack Whitehead of Greenwich, CT.

I would ask Mr. Whitehead as to whether he is here representing the Whitehead Institute or as a very expert, amateur tennis player. Jack it is good to have you here.

Mr. **Whitehead**. I am here as a concerned citizen.

Senator **Weicker**. You are a great friend, I might add, a great friend to research, medicine, science and this Nation. The Nation is deeply indebted to you, and I am especially proud to have you as my constituent.

Mr. **Whitehead**. Thank you, sir.

Thank you also for the opportunity to testify on behalf of the National Institutes of Health budget.

Before I begin my formal remarks, may I request that my written statement be placed in the record.

Senator WEICKER. It will be, in its entirety.

Mr. WHITEHEAD. I am Jack Whitehead. By way of background, I have experience on many sides of the basic research community. Mine is a lifelong record as a manufacturer of scientific instruments, and founder-donor of a large basic research institute.

I would like to take this opportunity to thank you for your support of biomedical research in years past, particularly Senator Weicker. Had it not been for the ardent support of the Senate, and, again, Senator Weicker, we would not have realized many of the scientific accomplishments in the last decade.

And yet, our mission is not yet complete. It is expected that cancer will kill over one-half million people this year, a cure is not on the horizon for AIDS, our nursing homes are dealing with growing numbers of older Americans diagnosed with Alzheimer's disease and cardiovascular diseases remain as a crippler and killer in every community in America.

We still have a long road ahead of us.

I am not a scientist. Therefore, I will not speak to you today about our scientific achievements or prospects. Rather, I would like to focus my remarks on our long-term investments in biomedical research—its structural needs.

Our biomedical research programs have been good business for this country. Research programs have created jobs, expanded the health care marketplace, improved our productivity, improved our balance of trade, and made efforts at reducing the cost of medical care in this country, much as the Senator just expressed.

We have, quite simply, flourished in this area in the past two decades.

And now, it has become apparent that the support structure of this rich resource is decaying and, in fact, impeding scientific progress. Our laboratories are overcrowded. They lack up to date equipment to facilitate our research projects.

As a result of this overcrowding, we have adopted a practice of robbing Peter to pay Paul.

To conduct AIDS research, it has been necessary for many organizations to forego research in other areas.

Gentlemen, it is disconcerting to pit science against science, to have to make a decision to direct resources for a cure for AIDS when a cure for diabetes is just as important, at least in the eyes of the diabetic.

An example of our overcrowded research facilities is a recent memorandum which was disseminated to researchers at a leading university. In essence, it stated that no more research applications would be approved by the university because there was no more space available in which to conduct the research.

What have we come to when bricks and mortar are preventing us from applying the scientific talents that we have in this country?

I recently participated on the committee convened by the National Institutes of Health to review the status of our research infrastructure and recommend to the Congress a program to ameliorate this problem. What the panel heard from the witnesses we convened was very akin to the findings of several recent studies.

The White House Panel on the Health of the U.S. Colleges and Universities or the Packard Commission, and the National Science Foundation have each issued recent reports regarding the research infrastructure as it relates to facilities and instrumentation.

The conclusions of each of these reports was similar and clear—we are working in a rapidly antiquating system and it is impeding our research initiatives.

In fact, the White House report alone estimated that it would take about $10 billion over the next 10 years to rectify the situation.

The nature and tools of medical research have fundamentally changed in the last 5 or 10 years. The cutting edge of today's research is at a molecular level.

The advances have been dramatic. Such tools as cell sorters, automated DNA sequencers, scanning confocal microscopes, protein sequencing machines, high blood pressure liquid chromatography, DNA synthesizers, various types of electron microscopy are commonplace.

Discoveries as recent as 2 weeks ago of a second genetic material will, once again, change the nature and tools of molecular biology.

Today's 20-year-old laboratory is outmoded. Research activity has been slowed down and, in turn, has slowed down the application of new techniques to diagnose and treat disease.

So often we say to persons afflicted with chronic or fatal diseases for which we have no cure yet, "You cannot speed up research, it is a science which builds step upon step."

However, we can and should provide research scientists with equipment and facilities that make optimum use of their expertise, and facilitate progress in their research initiatives.

In addition, improved health and safety requirements for our scientists and laboratory workers, increased need for environmental protection and new regulations for animal research facilities mandate improvements in the present infrastructure.

The last NIH appropriation for research facilities was in 1968, although some construction moneys have been available through the National Cancer Institute since that time. However, these funds have been limited and strictly designated for cancer related programs.

The long-term investment in the 1960's for our facilities has stood the test of time; but it needs reinforcement or our research facilities will slowly crumble with the hopes of millions of Americans afflicted with chronic and life-threatening diseases.

Many have stated the facts, both to the scientific community, the administration, and the Senate. We can no longer afford to put our research infrastructure on the back burner. Its needs are pressing, and we are walking on dangerous ground when we fail to insure safety in the laboratory.

Mr. Chairman, members of the subcommittee, I believe the time has come to turn our full attention to the problem and address the needs squarely.

I support the recommendation of the ad hoc coalition for biomedical research, to provide $250 million for support of biomedical research facilities in fiscal year 1989.

I believe that it will be a wise investment, which will carry us into the next decade, enabling many new scientific achievements, which will translate into a healthy America.

There is one more area that I would like to discuss before closing.

I am chairman of the board of the Friends of the National Library of Medicine. The board is pleased that last year this committee directed the National Library of Medicine to focus its considerable experience and expertise on the unique information handling requirements of biotechnology research, and funded a National Center for Biotechnology Information within that ideally suited resource.

Bills now in the Senate and House contain similar provisions establishing the National Center for Biotechnology Information as a component of the NLM.

PREPARED STATEMENT

To operate this critically needed center as proposed, the NLM will require $10 million. This is a very small fraction of our research investment in mapping and sequencing the human genome, the success of which rests to a considerable degree on information manipulation and the efficient transfer of research results.

Thank you for your valuable time. I commend you for your patience and leadership.

[The statement follows:]

STATEMENT OF JACK WHITEHEAD

Good morning Mr. Chairman and distinguished members of the Committee. Thank you for the opportunity to testify before you on behalf of the National Institutes of Health Budget.

Before I begin my formal remarks may I request that my written statement be placed in the record.

I am Jack Whitehead. By way of background, I have experience on many sides of the basic research community.

Mine is a lifelong record as manufacturer of scientific instruments, and founder-donor of a large basic research institute.

I would like to take this opportunity to thank you for your support of omedical research in years past. Had it not been for the ardent support of the Senate, we would not have realized many of the scientific accomplishments in the last decade which have been achieved.

And yet, our mission is not yet complete. It is expected that cancer kill over half a million people this year, a cure is not on the horizon for AIDS, our nursing homes are dealing with growing numbers of older Americans diagnosed with Alzheimer's disease, and cardiovascular disease remains as a crippler and killer in every community in America. We still have a long road ahead of us.

I am not a scientist; therefore, I will not speak to you today about our scientific achievements or prospects. Rather I would like to focus my remarks on our long term investments in biomedical research .... it's structural needs.

Our biomedical research programs have been good business for this ountry. Research programs have created jobs, expanded the health care marketplace, improved our productivity, improved our balance of trade and made efforts at reducing the cost of medical care in this country. We have, quite simply, flourished in this area in the past two decades.

And now, it has become apparent that the support structure of this rich resource is decaying and, in fact, impeding our scientific progress. Our laboratories are overcrowded and they lack up to date equipment to facilitate our research projects. As a result of this overcrowding, we have adopted a practice of robbing "Peter to pay Paul." To conduct AIDS research, it has been necessary for many organizations to forego research in other areas. Gentlemen, it is disconcerting to pit science against science, to have to make a decision to direct resources to look for a cure for AIDS when a cure for diabetes is just as important in the eyes of the diabetic.

An example of our overcrowded research facilities is a recent memorandum which was disseminated to researchers at a leading university. In essence, it stated that no more research applications would be approved by the University because there was no more space available in which to duct the research. What have we come to when bricks and mortar are preventing us from applying the scientific talents that we have in this ountry?

I recently participated on the Committee convened by the National Institutes of Health to review the status of our research infrastructure and recommend to the Congress a program to ameliorate this problem. What the panel heard from the witnesses we convened was very akin to the findings of several recent studies.

The White House Panel on the Health of the U.S. Colleges and Universities or the Packard Commission, and the National Science Foundation have each issued recent reports regarding the research infrastructure as it relates to facilities and instrumentation. The conclusions of each of these reports was similar and clear .... we are working in a rapidly antiquating system and it is impeding our research initiatives. In fact, the White House report alone estimated that it would take about $10 billion over the next 10 years to rectify the situation.

The nature and tools of medical research have fundamentally changed in the last five or ten years. The cutting edge of today's research is at a molecular level. The advances have been dramatic. Today, such tools as cell sorters, automated DNA sequencers, scanning confocal microscopes, protein sequencing machines, high blood pressure liquid chromatography, DNA synthesizers, various types of electron microscopy, are common place. Discoveries, as recent as two weeks ago, of a second genetic material will, once again, change the nature and tools of molecular biology. Today's 20 year old laboratory is outmoded. Research activity has been slowed down and, in turn, has slowed down the application of new techniques to diagnose nd treat disease.

So often we say to persons afflicted with chronic or fatal diseases for which we have no cure yet ... "you cannot speed up research, it is a science which builds step upon step." However, we can and should provide research scientists with equipment and facilitiies that make optimum use of their expertise and facilitate progress in their research initiatives. In ddition, improved health and safety requirements for our scientists and laboratory workers, increased need for environmental protection and new regulations for animal research facilities mandate improvements in our present infrastructure.

The last NIH appropriations for research facilities was in 1968, although some construction monies have been available through the National Cancer Institute since that time. However, these funds have been limited and strictly designated for cancer related programs. The long term investment in the 1960's for our facilities has stood the test of time, but t needs reinforcement or our research facilities will slowly crumple with the hopes of millions of Americans afflicted with chronic and life-threatening diseases.

Many have stated the facts, both to the scientific community, the Administration and the Senate. We can no longer afford to put our research infrastructure on the back burner. Its needs are pressing, and we are walking on dangerous ground when we fail to ensure safety in the laboratory. Mr. Chairman, Members of the Subcommittee, I believe that the time has come to turn our full attention to the problem and address the needs squarely. I support the recommendation of the Ad Hoc Coalition for Biomedical esearch... to provide $250 million for support of biomedical research facilities in Fiscal Year 1989. I believe that it will be a wise investment which will carry us into the next decade, enabling many new scientific achievements which will translate into a healthier America.

There is one more area which I would like to discuss before closing. I m Chairman of the Board of the Friends of the National Library of Medicine. The Board is pleased that last year this Committee directed the National Library of Medicine to focus its considerable experience and expertise on the unique information handling requirements of biotechnology research, and funded a National Center for Biotechnology Information within that ideally suited resource. Bills now in the Senate and House contain similar provisions establishing the National Center for Biotechnology Information as a component of the NLM. To operate this critically needed center as proposed, the NLM will require $10 million. This is a very small fraction of our research investment in mapping and sequencing the human genome, the success of which rests to a considerable degree on information manipulation and the efficient transfer of research results.

Thank you for your valuable time. I commend you for your patience and leadership.

Senator WEICKER. Jack, thank you very much. Your counsel is highly valued on the committee.

I have no questions. Your statement in its entirety will be placed in the record.

Again, it is an effort for you to come down here and we appreciate your being here.

Thank you.

Mr. WHITEHEAD. Thank you, Senator.

STATEMENT OF GERTRUDE AND IRVING SWERDLOW, COFOUNDERS OF FACT: FAMILIES AGAINST CANCER, INC.

Senator WEICKER. Our next witnesses are Gertrude and Irving Swerdlow of Families Against Cancer.

Ms. SWERDLOW. Mr. Chairman, this water looks very good.

Senator WEICKER. If you or anybody else has been dying for that water, please be my guest. It is the least the Government owes you, a glass of water. [Laughter.]

Ms. SWERDLOW. Sometimes I think it forgets that.

Mr. Chairman, we want to thank you and the committee for inviting us to participate in this extremely important hearing.

We are Irving and Gertrude Swerdlow, cofounders of FACT: Families Against Cancer, a national organization located in Syracuse, NY.

FACT is a grassroots organization of families that know intimately the burden of cancer. We lost our dear son, Dr. Paul Herschel Swerdlow, to leukemia in 1985. He worked on early cancer detection.

Our program's purpose is to arouse the consciousness of the American people to the terrible costs and suffering related to cancer, to increase the resources that are made available to help the families affected by cancer, and to increase research that can bring closer the day when cancer can be overcome.

Mr. Chairman, a serious lag exists between cancer statistics, published by this Government on the one hand and what this Government appropriates to the NCI on the other hand.

For example, $1 billion was appropriated in fiscal year 1980. During the following 3 fiscal years, nominal moneys actually declined, and increased only slightly in fiscal year 1984.

For fiscal years 1981 through 1988, moneys increased by 40 percent, while the CPI rose approximately 30 percent. Costs for medical commodities and services rose by more than 40 percent, resulting in an actual decline of constant dollars.

Nearly 4 million persons died of cancer in those 8 years.

Let us equate the following costs with these NCI appropriations: a child born in the mid-eighties has 1 in 3 chances of coming down with cancer in his lifetime; a child born today has less than 1 in 5 chances of surviving cancer during his life cycle; cancer is the No. 1 cause of death from ages 14 to 54; it continues to kill more children than any other disease; it is the No. 2 killer after age 54, while it remains No. 1 for our children and grandchildren; foregone earnings and medical care costs resulting from cancer exceed $70 billion annually; and lost Federal taxes approach $8 billion annually.

Nearly 1 million cases are diagnosed each year and 5 million treated each year. The people are fearful and angry. They are skeptical that the Government cares. They want survival from cancer more than a 40- to 49-percent option.

They know that a small fraction of 1 percent of $1 trillion budget is inadequate to the problem.

When we fight cancer, we tackle not one disease, but, rather, a family of diseases, all related by a process that causes human cells to disregard their natural growth signals.

During the past few years, we have seen significant breakthroughs. Every discovery opens new vistas for exploration and treatment. Effective research must constantly grow, both in complexity and opportunity.

Trained staff must be retained and stimulated by the vigorous pursuit of new ideas. When only 30 percent of approved NCI proposals can be funded, then our efforts are very inadequate.

We can no longer base our NCI budget on past periods. We must base our budget on current and future needs. Cancer is the plague of the late 20th century. Families endure stresses that frequently tear apart otherwise loving persons.

Services to counsel patients and patients' families are sorely lacking.

FACT, therefore, recommends approval of the NCI budget request for fiscal year 1989 of $2.08 billion, including $122 million for AIDS, as basic and reasonable.

This is not a dream budget, but realistic to the problem and to the Institute's capacity to make use of the money.

The human capital is available to put these resources to use immediately against a brutal killer. Moneys need not be siphoned from other medical programs. This is not sibling rivalry. This is but one of many items in the discretionary budget, many of them more generously financed and totally unrelated to the saving of American lives.

FACT represented 5,000 persons last year. Today we speak for 30,000, and will represent twice that number by the end of this year.

We will stand up and be counted, and we will remark how our Government responds.

PREPARED STATEMENT

Cancer will become our national issue. We sincerely ask your support for the proposed NCI budget of $2.08 billion.

We thank you, Mr. Chairman, for this opportunity to speak before you and the committee.

[The statement follows:]

STATEMENT OF IRVING AND GERTRUDE SWERDLOW

Mr. Chairman, we want to thank you and the Committee for inviting us to participate in this extremely important hearing on cancer. We are Irving and Gertrude Swerdlow, co-founders of FACT, Families Against Cancer, a national organization located in Syracuse, New York. FACT is a grassroots organization of families that know intimately the burden of cancer. Our program's purpose is to arouse the consciousness of the American people to the terrible costs and suffering related to cancer; to increase the resources that are made available to help the families affected by cancer; and to increase research that can bring closer the day when cancer can be overcome.

Mr. Chairman, a serious lag exists between cancer statistics published by this Government on the one hand, and what this Government appropriates to the NCI on the other hand. For example, one billion dollars was appropriated in FY/80. During the following three fiscal years nominal monies actually declined, and increased only slightly in FY/84. For the fiscal years 1981 through 1988, monies increased by 40 percent while the CPI rose approximately 30 percent. Costs for medical commodities and services rose by more than 40 percent, resulting in an actual decline of constant dollars. Nearly four million persons died of cancer in those eight years.

Let us equate the following costs with these NCI appropriations:

1. A child born in the mid-80's has one in three chances of coming down with cancer in his lifetime;
2. A child born today has less than one in five chances of surviving cancer during his life cycle;
3. Cancer is the number one cause of death from ages 14-54;
4. It continues to kill more children than any other disease;
5. It is the number two killer after age 54, the 'golden years', while it remains number one for our children and grandchildren;

6. Foregone earnings and medical care costs resulting from cancer exceed $70 billion annually;

7. Lost federal taxes approach $8 billion annually.

Nearly one million cases are diagnosed each year. In any one year, about five million cases of cancer are undergoing treatment. Already, the NCI goal to reduce cancer deaths fifty percent by the year 2,000 has fallen behind schedule.

The people are fearful and angry. They are skeptical that the Government cares. They want survival from cancer more than a 40-49 percent option. They know that a small fraction of one percent of a trillion dollar budget is inadequate to the problem. How does a father answer his nine year old child, whose hair is gone and locomotion impaired, when she asks: "Why doesn't God love me?"

When we fight cancer, we tackle not one disease, but rather a whole family of diseases, all related by a process that causes human cells to disregard their natural growth signals. Each cell of the billions of cells in the human body has incorporated, in its structure, instructions that tell it how to grow, mature and, if necessary, to die and be replaced by another human cell. When these 'normal' cell instructions are altered, the cell often grows and multiplies in a wild manner, causing tumors that can often cause death. Sometimes, the tumor cells break off and travel through the blood stream until they attach themselves to another place in the body and continue to grow wildly. While the normal immune system usually attempts to fight off the efforts to change the growth instructions of the cell, its efforts are too often inadequate, and tumors result.

During the past few years we have seen significant 'break-throughs.' Some of these discoveries related to treatment or elimination of tumor growth; others have focused on how cancers metastasize. Others relate to early detection. Some discoveries point to the use of specific anti-bodies to control cancerous growth. Still others explore new means by which the immune system can be triggered to better defend the body from cancer.

Every discovery opens new vistas for exploration and treatment. Every addition to the knowledge we have developed about how the normal cell grows and multiplies, how the immune system attacks and destroys invaders modifying the cells' growth instructions, requires additional studies and new advances. Effective research must constantly grow both in complexity and opportunity. New methods must be developed. New equipment, particularly computers and scientific testing and analytical equipment, have lagged because so little has been budgeted in the recent fiscal years. Similarly, ability to add space, particularly research laboratories, has been curbed by budgets that are more concerned with the previous year's appropriation than with the critical needs to expand research. Trained staff must be retained and stimulated by the vigorous pursuit of new ideas. When only 30 percent of approved NCI proposals can be funded, then our efforts are inadequate.

When, as in the present case, no new buildings or laboratories are included in the capital budget for almost five years, then our efforts are inadequate.

We must no longer base our NCI budget on past periods. We must base our budget on current and future needs. The myth yet prevails that the Government is doing all possible to cope with the mysteries of cancer. The time has come to inform the American public otherwise. The federal budget continues to be an arcane instrument to the average American who has inadequate knowledge how that trillion dollars are expended. On the revenue side of the budget tax expenditures amount to many tens of billions of dollars. How can a nation possibly mobilize itself against an enemy that attacks our 'healthy' loved ones if it locks itself into a discretionary budget and plaintively asks, "Cancer is already getting more money than other health research. Shall we take it away from other health seeking programs?" No, indeed. This nation has a GNP of five trillion dollars. It provides government support to programs totally unrelated to survival and quality of good health. The people should be made aware that dozens of diseases falling under the term 'cancer' may take billions of dollars annually to overcome. The rewards in human life and income foregone await this decision.

Avenues can then be opened to make senior research staff competitive at the NCI with similar colleagues in the private sector and academia. An expanded program to defeat cancer will see hundreds and thousands of young people gravitate to where those jobs are created. We have the talent. Let us put it to work for our needs. Don't let it die of cancer.

The costs of cancer in both human lives and in money are simply too great to be continued. Our society must try to evaluate more accurately how many resources can be effectively used to fight cancer, and make every effort to allocate such resources.

Cancer is the plague of the late 20th Century. Families endure stresses that frequently tear apart otherwise loving persons. Services to counsel patients and patients' families are sorely lacking. We must make available all the resources needed to fight cancer and to cope with cancer. To do otherwise is costly in human capital, earnings and taxes foregone, and explosive medical care costs.

FACT, therefore, recommends approval of the NCI budget request for FY/1989 of $2.08 billion, including $122 million earmarked for AIDS as basic and reasonable.

This is not a dream budget, but realistic to the problem and to the Institute's capacity to make use of the money. The human capital is available to put these resources to use immediately, against a brutal killer. Monies need not be siphoned from other medical programs. This is not sibling rivalry. This is but one of many items in the discretionary budget -- many of them more generously financed and totally unrelated to the saving of American lives.

This nation was galvanized when a toddler fell into a dry well last year. What is our agony for the thousands of young who died from cancer or cancer related causes last year?

FACT represented 5,000 persons last year. Today we speak for 30,000 and will represent twice that number by the end of this year. We will stand up and be counted and we will remark how our Government responds. Cancer will become our national issue. We sincerely ask your support for the proposed NCI budget of $2.08 billion. We thank you, Mr. Chairman, for this opportunity to speak before you and the Committee.

Senator WEICKER. Gertrude and Irving, thank you very much. What a great way to honor your son.

I will also say—and this gets back also to a comment that Jack Whitehead made—that the problem with this great budget agreement that was arrived at is that the military portion of the budget is sacrosanct, and, therefore, the discretionary spending portion outside the military pits science against science. It is as simple as that.

This is of much concern, indeed, and being discussed now within the Appropriations Committee are figures that are less than those proposed by the President. And he has never been overly generous here, believe me.

Ms. SWERDLOW. Mr. Senator, we understand your statement very well. Both my husband and I spent many years teaching economics, and one of our favorite examples of how we set our priorities has been the Federal budget.

We recognize that the priorities for health have really not been adequate in this country, and we appreciated your statement earlier in the hour to this effect.

We hope that fact will bring the American people together to speak up and demand more of their Government.

Senator WEICKER. I think it is a great idea.

I'm going to tell you that we have had all sorts of organizations that have had a tremendous impact on legislation. It is not a question that this is some quixotic adventure that you are on.

I suppose the thing that comes to mind most readily is the Mothers Against Drunk Drivers. They went ahead and literally got Congress to do what it should have done before vis-a-vis speed limits, drunkenness, and all the rest of it.

My goodness, if we can do that with drunk driving, which is a killer, we can certainly do it on cancer, which is just as much, if not more, of a killer.

Ms. SWERDLOW. We are hoping to do that. We were in Albany just 3 or 4 days ago, and we are getting the State of New York to be the first State in the Nation to come out and say that it is declaring a true war against cancer.

We have no paid workers, Mr. Senator. All work is voluntary. We have turned over our home to the offices of the organization, and we operate on a shoestring, and do so very successfully.

Thank you.

Senator WEICKER. God bless you both.

Thank you very much.

STATEMENT OF GRACE POWERS MONACO, J.D., NATIONAL LIAISON CHAIRPERSON, CANDLELIGHTERS—PARENTS OF CHILDREN WITH CANCER

Senator WEICKER. Next is Grace Powers Monaco, the national liaison chairperson of the Metropolitan Washington Area Candlelighters.

Grace, it is nice to have you back.

Ms. MONACO. It is wonderful to be back for the 18th year.

When we first started testifying in 1970, which was shortly after the death of my daughter, Kathleen Rae, from cancer, we had four groups, which were Florida, District of Columbia, California, and

Connecticut. Today, we have 250 groups in our parent support network.

Although I have a prepared statement, which I know is going to be included in the record—and I do certainly make some points in that about the level of funding that we would like to see, and also point out, I think rather dramatically, a new problem that we have in making the cancer dream come true in terms of cure, which is that the high priced technologies which are not being covered by insurance today are really making it impossible for us to complete the types of clinical trials we know we need to complete in order to translate some of these treatments into standard medical practice—I kind of want to put that aside because of your comments earlier on what do we do to wake up the American people to the importance of funding research.

I have a very favorite philosopher, someone I am sure you are well familiar with, by the name of Mae West.

Senator **Weicker**. Why do you think the chairman should be familiar with Mae West? [Laughter.]

Ms. **Monaco**. I think, as the chairman has always had good taste, and she is one of our better exemplars of good taste in comedy, and she says, "Too much of a good thing is wonderful." [Laughter.]

I know that that is what you want for the whole cancer community. I know that we have pretty close to that for the pediatric cancer community.

When I started testifying, 10 percent of our kids were being cured. Right now, we have 65 percent of our kids that are being cured—75 percent if we could get them all into center-related treatment, and the excellent plans of NCI that are working on more of the molecular basis may tell us how to save another 15 percent and how to repair the genetic defects in some of our children who are at risk for abdomicoma and Wilms's tumor and neuroblastomas and the like.

So I think that pediatric cancer has been a model for what we can do when everybody works together to solve a problem from the roots up. What does that do to wake the American public up?

Right now, if you took the number of children that we are returning cured each year because of the advances in research and you estimated the amount of funds that they were going to return to this country over their lifetime of work, which is going to be an average of 50 years per child, we are paying for the entire National Cancer Institute research program just based on the saved lives of our children.

Now, I think that is the kind of message that we need to get across to the American people, that our gross national product is enhanced by returning excellent people who can be cured to the marketplace.

I will say that our children who are being treated for cancer are going into medical careers, and, although most of them are going to feel the little pinch of maybe our doctors aren't making as much money, they are looking to high profile, well paid occupations.

So I think we can see that they are going to return a lot to the gross national product.

I don't know how we can help you, Mr. Chairman, get this message across. But I do know that if it takes marches and candlelight tours and sitting in the middle of the street, I think maybe the time now, just as it was in 1970, is to get out again and really tell the American people that if they cut our throats on research, they are going to drown in their own blood in another 10 years, and they are going to see the one product that we have that no one in the world can match, which is excellence in medical treatment and cure, the one thing we can export always with no trade deficit problems, get flushed right down the tubes.

PREPARED STATEMENT

So, please, do call on us whenever you can and tell us how to be involved to help you get this message across. We are ready to do whatever it takes.

Thank you once again for listening.

Senator WEICKER. Grace, thank you very much for your testimony. I appreciate it greatly.

[The statement follows:]

STATEMENT OF GRACE POWERS MONACO

My name is Grace Powers Monaco. I am National Liaison Chairman of the Metropolitan Washington Area Candlelighters. This association serves as the legislative arm of an international volunteer coalition of 250 groups of parents whose children have or have had Cancer in 50 states and Australia, Canada, Chile, Denmark, England, Finland, France, Germany, Greece, Guatemala, Holland, India, Indonesia, Ireland, Israel, Italy, Mexico, New Zealand, Sweden, South Africa, Spain and East Africa.

Twenty years ago if you were to mention oncogenes, monoclonal antibodies and fighting cancer with killer T cells, people would have thought that you had come from a screening of Buck Rogers in the 21st Century. Twenty years ago it was heady news indeed that we were getting a handle on the subclassifications of childhood cancers so we could treat each tumor type individually and better.

Ten years ago you would have received the same response if you mentioned that gene malformations or omissions that cause some cancers might possibly be corrected in the body in the future.

The National Cancer Institute approach to childhood cancer has been a tribute to careful planning and innovation. It is a tribute to both the dreamers and the doers that has increased the cures of pediatric cancers from 10% to 65% and climbing in 25 years; produced over 55,000 adult survivors of childhood today and has even brought recognition that childhood cancer patients can be truly cured from the armed services and service academies who now on a case by case basis are acknowledging that our cured kids can serve their country in the military.

With this history, it is good news that NCI has pressed into service the skills of the same people who cracked the leukemia treatment mystery to address treatment for pediatric and infant AIDS.

By and large the budget that CCCF would like to see is the bypass budget which is supported by the National Coalition for Cancer Research which we are members of. We have a few additional requests which are included in an appendix to this testimony.

We have requested increases in basic research, intramural research, centers and clinical trials greater than the bypass budget. The advances we are projecting for the next boost in pediatric and adult cures and controls of cancer comes in great part from studies related to biology and molecular biology and a need to further understand the use in the natural and augmented state of biological response modifiers. To do this appropriately we need also to be able to collect and analyze data on a national basis.

The funds currently being parceled out to achieve these objectives are not sufficient to yield the quality and quantity of information that will produce rapid results. CCCF is not content to wait needlessly for an improvement in the cure rates for our children and to await treatments that will not have the effect of producing minimal brain dysfunction on our children. The biologicals being investigated and developed, and if money is there, swiftly proven out in clinical trials will enhance the numbers of our children being saved and the quality of the productive lives they can and deserve to live.

Actually I am asking for no more than our children have paid for themselves. We are now returning 4,000 plus children to society as cured each year. The lifetime anticipated addition to the gross national product from these children's lives each year amounts to more than the costs of the entire National Cancer Program.

Let me put it this way--we are asking for an advance on our inheritance.

There is one additional figure contained this year in CCCF's request for additional funds for clinical trials. It is a component to pay for a pilot program in reimbursement,-- the patient supportive care costs for patients enrolled in trials for several high cost technologies.

Contrary to popular opinion there is not sufficient money available in conducting clinical trials either of new agents or older agents being used for new (unlabeled) purposes to routinely pay for the in hospital and supportive care costs of the patients giving of themselves to further knowledge and find and perfect cures through participation in research.

The lack of funds to pay for supportive care places the ball back in the patients court. If your insurance company pays, you can participate in the trial; if it does not, you may not. Insurance companies usually exclude payment for experimental/investigational trials.

Why?

Traditionally this was believed to be within the purview of the developers of new drugs and technology and of the government or philanthropist funding research.

The insurers as I understand it saw themselves as paying for the care that was had been demonstrated to be ready for standard application and use; care that had already been through Phase II trials to determine its potential efficacy in treating a disease, and had been compared against standard therapies in Phase III trials giving us a good idea of its "place" in cancer treatment. Insurers did not consider themselves paying for "hope" but for realistic "help" as the best use of premium dollar.

With the shrinking health care dollar, all that has changed. Insurers are being asked more and more to pay for treatments that might be all that is left for a particular patient but which have not established themselves as providing patient benefit .

There are dialogues proceeding on this issue of who should pay for supportive care costs in investigational therapies and clinical trials including treatment IND use. Certainly if employers agree to pay for this benefit, its cost spread over the employee population will not be great.

However, while attempts are ongoing to resolve this in the private sector, should patients be deprived of the opportunity to be a research subject if they fit the profile for a trial because they cannot afford to pay? Should they be deprived of care with curative intent that is considered by most physicians to be the best and most appropriate level of care for them? Should we have to wait 10 years for an answer on improved therapies or new therapies because we can't enroll sufficient patients in trials which will answer benefit questions because they cannot afford to pay?

Every month I see the records of pediatric and adult cancer patients who have been told that a particular high tech treatment is the only therapy holding out some hope for them.

In some of these cases which do not come from treatment centers participating in controlled trials, the patients do not appear to have been appropriate candidates for the procedure because they would have been excluded for organ function deficiencies from the published protocols. In those cases one wonders whether marketing motivated the suggestion of the treatment rather than propriety.

In most of the cases, however, certainly in the cases coming from the NCI supported clinical trials programs, the patients and families have seen a well defined protocol and informed consent, truly understand that the chance for them is small but are willing to take the risk in hopes they will benefit but if not that they are helping others in the future. To then be told that it is doubtful that your insurance will cover this and you have to raise 30,000 to 100,000 before we can commit to giving you the treatment is psychological torture at its most extreme. It also makes the federal government out to be a liar of the worst sort.

When the federal government supports trials, patients do not understand that at present they just support the cost of the drug, the physician and trial management for example. Doesn't the public have a reasonable expectation that the guinea pig's costs, the person without which it cannot proceed will not have to pay to be a guinea pig?

Would it really cost that much to include patient care costs in clinical trials? Are you willing to appropriate funds for a pilot program on several cancers and technologies to test it out? I am asking for an additional 30,000,000 which should, on balance pay for the hospital and clinical supportive care and uncovered (e.g., LAK cell) costs for about 1,000 patients on clinical trials and ask that if you decide to pursue this pilot program approach that you direct NCI to develop and outline a pilot program that will demonstrate the impact of this approach on cancer control.

Without the type of support I am referring to resolved I hope eventually and soon in the private sector with the federal government acting as a bridge across the river while the solution is being worked out, we are diminishing the ability to continue to develop the high technology medicine which is one area in which we do not have a trade deficit.

Thank you for all your help and support to our children in the past.

Mr. Chairman, Members of the Committee, on behalf of all parents of children with cancer across the country, I should like again to commend the Chairman and the Members of the Committee for their many efforts and their understanding of our problems. Your dedication to the cause, the cure and the prevention of cancer encourages us to face the future with a greater degree of hope and peace of mind. Those of us who have lost children are under treatment are grateful for the hope which research gives us in maintaining their well-being.

We gratefully acknowledge the part of the Committee has played in this effort to conquer this dreaded disease. Thank you for permitting us to appear before you.

APPENDIX I

NATIONAL CANCER INSTITUTE
1989 BUDGET

(Dollars in thousands)

PROGRAM	1989 REQUEST	SUGGESTED INCREASE	FULL AMOUNT
Intramural research	281,625	42,243	323,868
Cancer Centers	135,000	6,750	141,750
Cooperative Clinical research	89,657	8,965	98,622

plus 30,000 for pilot reimbursement project.

STATEMENT OF BERT VOGELSTEIN, M.D., ASSOCIATE PROFESSOR OF ONCOLOGY, THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE, ON BEHALF OF THE AMERICAN ASSOCIATION FOR CANCER RESEARCH

Senator WEICKER. Next is Dr. Bert Vogelstein, associate professor of oncology, the Johns Hopkins University School of Medicine, and representing the American Association for Cancer Research.

Dr. Vogelstein, it is good to have you.

Dr. VOGELSTEIN. Thank you, Mr. Chairman.

For the first time, I can report to you that we have made dramatic strides in one battle in cancer, that is the battle to understand what cancer is, what causes cancer, why cells proliferate abnormally.

In the last 5 years, researchers have been able, for the first time, to identify the heart of the cancer problem—that is, a group of genes called cancer genes or oncogenes, which are present in all of us, but they lie dormant, like little time bombs, until activated by carcinogens or spontaneously, at which point they cause the uncontrolled proliferation of cells, which we see clinically as cancer.

Now, this research is really a dramatic breakthrough. It is the first time that we are beginning to understand the basis of cancer, perhaps analogous to the discovery of polio viruses and the fight against that disease.

The second point is that most of these discoveries—in fact, almost all, were made in the United States, supported by the National Cancer Institute, through funds appropriated through your foresight and that of your colleagues.

We are the unquestioned leader in biomedical research of cancer.

How do we continue that leadership, and, more importantly, how do we begin to apply these fundamental discoveries to the aid of patients with the disease?

I would like to at least suggest two specific areas, both relatively inexpensive, but which have a high return.

The first is training programs. Training programs are responsible for training at the pre- and postdoctoral levels, scientists who will carry on this fight in the coming decades.

This training serves two purposes. First, the trainees themselves actually perform most of the experiments done in cancer research laboratories. Second, these dedicated young people, who work 70 to 80 hours per week at far less than minimum wage, are really representing the future of cancer research in this country.

By supporting a level of 1,600 trainees in the next fiscal year, I think we can insure the continued success of that program.

Second, is the issue of the infrastructure. Currently, there are no funds from the National Cancer Institute to support the upgrading of existing laboratories in order to keep them technologically up to date.

PREPARED STATEMENT

We support the National Cancer Institute's target of $10 million for that purpose, which is a relatively modest request, but needed to continue state-of-the-art research.

I thank you for the opportunity to present these issues to you and I would be happy to answer any questions you might have.

[The statement follows:]

STATEMENT OF BERT VOGELSTEIN

I am Bert Vogelstein, M.D., Associate Professor of Oncology at the Johns Hopkins University School of Medicine and Cancer Center. I am honored to have the opportunity to speak to you on behalf of the American Association for Cancer Research. We are deeply appreciative to this Congress and previous Congresses which have traditionally provided excellent support for the biomedical research needs of this nation. Needless to say, we all recognize that our biomedical research programs have made unique contributions to improved productivity, reduction of the cost of medical care, and prevention and treatment of disease.

The American Association for Cancer Research is a professional society of cancer researchers founded in 1907. The members of our Association are the scientists in medical schools and universities, research institutes, and government laboratories who direct their studies to problems of cancer causation, cancer treatment and understanding of the cancer problem so that this dread disease may some day, like smallpox and polio, be relegated to the list of conquered human problems.

The war against cancer is now being fought on two fronts: clinical and basic. The basic studies are aimed at discovering the mechanisms underlying the abnormal growth of cancer cells. In the last few years, dramatic victories in this war have for the first time been obtained. Researchers have been able to precisely identify what is wrong with many kinds of cancer cells, why these cells grow abnormally, and how they kill patients. The defects lie in a set of "cancer genes". These genes exist in all of our cells, much like little time bombs, and do not cause any harm under normal circumstances. But when mutations in these genes occur, either through carcinogenic agents or spontaneously, they in a sense explode, causing the runaway growth of the cells that contain them. I cannot over-emphasize the importance of these new breakthrough studies. They are perhaps analagous to the discovery of the polio virus. Only after the polio virus was discovered was it possible to design effective new approaches to control the polio disease. These approaches were impossible prior to knowledge of disease mechanism. Similarly, now that the cellular mechanisms of cancer are being unraveled, novel approaches to therapy or prevention will inevitably follow.

It is important to realize that the great majority of these new studies in basic cancer research have been performed in the United States through National Cancer

Institute funding. We are unquestionably the world leaders in this area of biomedical research, a leadership which should be a great source of pride to all Americans. To continue this leadership will require continued funding, and my purpose today is to ask that two specific areas be given special consideration.

First, training programs are among the most critical of those supported by the National Cancer Institute. As you know, the National Cancer Act gave to the National Cancer Insitute the responsibility to train clinicians and researchers. The young people supported by these training programs are among the most motivated and talented members of our society. They often work 70-80 hours per week for far less than the minimum wage. Their training actually serves two purposes. One purpose is obviously to give them the education necessary to become independent investigators. But secondly, these trainees actually perform most of the experimental work in cancer laboratories and thus they are in a very real sense responsible for most of the advances in biomedical research that have been made. Dollar for dollar, these training programs represent perhaps the best research investment possible.

The training of biomedical scientists is a long term process requiring a minimum of 8 to 10 years after baccalaureate education. Because of this long lead time, provisions are needed now to make sure that trained experts will be available in the short term as well as the long term. We reject the notion that providing trained experts to deal with the complexity of cancer research is akin to turning on and off a faucet. Unless we begin today to heed the concerns of the research community, at some point in the near future, when we turn the faucet on, there will be no water avaiable. It will take decades to replenish the supply of scientists.

The National Academy of Sciences and the National Cancer Foundation have recently released data which indicates the shortage of biomedical scientists and they are predicting that this shortage will grow in the near future. We need to make the downpayment now for 1600 cancer trainees that will enable us to provide trained investigators into the next century.

The second critical area of funding invovles the maintenance of research infrastructure. In order to maintain our world leadership in cancer research, and to apply the gains in understanding that have been made, construction funds are needed to upgrade cancer research, treatment and control programs at academic and medical institutions throughout the country. The failure to provide resources for the National Cancer Institute for construction will have a deleterious effect on our cancer research facilities. The AACR strongly urges the Congress to consider the NCI's bypass request of $10 million for 1989.

The members of this Committee are undoubtedly aware of the enormous health problem that cancer represents. Over 1,000 Americans die every day from cancer, so that a half million will die this year alone. This problem will not go away by itself and in fact, as the demographic profile of this country changes to include a greater percentage of older individuals, cancer will become even more of a public health problem. Research provides the only way out of this quagmire. We must continue to unravel the secrets of cancer cell growth and to apply this knowledge to implement new means of prevention and eventually to provide better cures for those common cancers which continue to elude us. The spectacular progress in recent years in understanding the biologic basis of cancer growth and in curing some specific types of cancer provides concrete evidence of the productivity of these research programs. The determination of our citizens to rid themselves of this dread disease and the generous support of the Congress have been responsible for this remarkable progress. Training the best and the brightest and then giving them the laboratory facilities which they need is the most effective way to continue our battle. We are gaining and the fight must be fought to ultimate victory.

Senator **Weicker**. Dr. Vogelstein, thank you very much. I have no questions. I think you indicate progress, but we still have a long way to go here.

Dr. **Vogelstein**. Sure.

Senator **Weicker**. We can only do it by virtue of the efforts of you and many like you around the country.

Thank you very much.

Dr. **Vogelstein**. Thank you.

Senator **Weicker**. We now move to another area.

Have I left out anybody who is here to testify vis-a-vis the Cancer Institute, before we move on to the dental research effort?

[No response.]

STATEMENT OF SIDNEY FREDERICK, D.D.S., LAFAYETTE, LA

Senator **Weicker**. Then next we will hear from Dr. Sidney Frederick, of Lafayette, LA.

Dr. Frederick, it is nice to have you.

Dr. **Frederick**. Thank you, Mr. Chairman and members of the committee for allowing me to appear before you. I am here to solicit your help in solving a very serious problem affecting the dental health of every individual.

My written statement gives you an idea of the importance and the seriousness of the problem. Until now, Congress has been concerned with providing the funds for dental research. But now I would urge you to become interested in the scientific aspects of this facial muscle phenomenon.

It is not only a dental problem; it is a medical problem also, as the dental health of the individual plays a major part in this phenomenon.

I have explained a serious void in our education and knowledge of the anatomy of this facial area [indicating]. At this point, let me stress that the dental profession is a hard-working, conscientious one, always seeking ways to improve dental health.

There are more continuing education courses in dentistry than in any other profession. Our great institutions take pride in preparing the students as well as possible. But in this one area, there is a serious and destructive phenomenon that has been undetected until now.

No one is to be faulted for this. But, when it is pointed out to the authorities and no one takes interest in correcting the situation, it is a different story.

It seems that no one wants to admit that something so significant has been missed. If you discuss this with anyone in the scientific community, and they start talking about a theory and scientific evidence, ask them to produce the scientific evidence that the anatomy of this area of the face that has been taught to all students is correct and complete and has fully prepared each student to do his or her best at his or her chosen profession.

They can't do it. And if they would try, they would prove that I am correct.

I explained my attempts to discuss this matter with the National Institute of Dental Research for 3 years, unsuccessfully.

My letter to the Surgeon General asking for help went to the same office in NIDR that has been refusing to discuss this with me.

The Surgeon General has received bad advice from his dental section.

I am a great admirer of the Surgeon General and like the way he attacks health problems. It is the way he goes after things that he believes to be correct that inspired me to confront the entire scientific community in an attempt to correct this serious and unacceptable situation.

What was written in anatomy books over 100 years ago about this area of the face [indicating] and taught to me in dental school over 50 years ago has been repeated without question or careful analysis, until I recognized something was wrong and set out to find out what it was.

A study of the anatomy books reveals a partly incorrect, incomplete, and inadequate descriptions of the muscles of this area. There is no mention of how these muscles function and the relationships and the effects of these functions on the dental tissues of this area of the face [indicating].

If the Surgeon General had a hint of the serious and far reaching implications of this phenomenon, I'll bet he would want to know the complete story.

The National Institutes of Health are in a perfect position to quickly correct this major defect in our education. If you get this one situation corrected, it would top the list of research projects as regards benefits to education, industry, and, ultimately, the patients.

This could be the most important project since fluoridation, and it would probably surpass fluoridation in importance.

PREPARED STATEMENT

Therefore, I respectfully ask the committee to ask the Surgeon General to conduct a thorough investigation of the entire matter, with the aim of providing better dental health care for all.

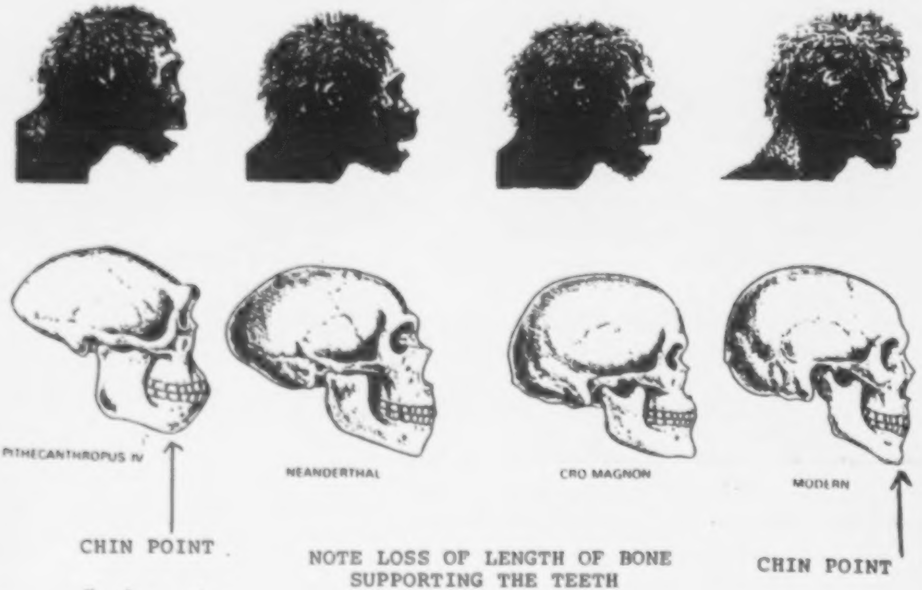
Thank you, sir.

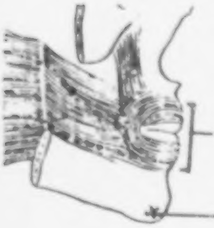
[The statement follows:]

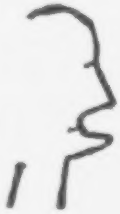
STATEMENT OF SIDNEY FREDERICK

Thank you, and the members of the Committee, for allowing me to appear before you. I am a dentist, an orthodontist, and I am seeking your help to solve a very serious problem concerning the dental health of every individual. Congress has been quite concerned about the dental welfare of all and has been very generous in providing the funds for dental research. We all owe you a sincere "Thank You" for what you have done.

THE EVOLUTION OF MAN'S PROFILE AND SKULL


PITHECANTHROPUS IV
NEANDERTHAL
CRO MAGNON
MODERN
CHIN POINT
NOTE LOSS OF LENGTH OF BONE SUPPORTING THE TEETH
CHIN POINT


MUSCLE SQUEEZE IS ON PART OF BONE THAT SUPPORTS THE TEETH ONLY!
NO PRESSURE ON BODY OF LOWER JAW


FUTURE MAN?
HOW FAR WILL IT GO?

For over twenty-five years, I have been studying the muscles surrounding the mouth and their effects upon this area of the face and the dental tissues which lie underneath. Several important discoveries were made. I have discovered specifically how these muscles have produced the changes in man's profile and skull as shown in the diagram above. The forces that produced these changes have been with us, are with us today, and will continue to be with us until the end of time. The factors involved are the length and strength of the muscles and the density of the bone. Since the density of the bone depends upon the general health of the individual, the medical profession is involved also. Some medical factors that cause a decrease in bone density are: natural aging, women's inability to keep and utilize calcium, prolonged illnesses, poor quality of diet, pregnancies, and texture of diet. Any of these, or a combination that causes the bone to become less dense or softer, makes the bone more susceptible to being scrunched into smaller size.

These muscles are like a curtain in the cheeks and lips and exert a constant pressure upon the bone supporting the teeth, causing a pressure resorption of the bone and gums. In the diagram note the loss of bone in which the teeth are set. The traditional number of teeth are trying to fit in the shortened bony arches. This is the number one cause of malocclusion - "crooked teeth" or "bad bite" that you hear so much about. This condition affects almost all phases of dentistry directly or indirectly and can result in the loss of teeth in many cases. Every single person is affected by this, no exceptions; it is a question of how severe. This is the most significant tissue behavior ever as far as this area of the face is concerned; yet, it is unrecognized by the dental and medical related professions. We have also discovered how these muscles can be weakened to help stop or reduce the tissue destruction. This is to be considered only as a start in treatment of this condition. More studies and research are needed in this area.

There are too many details to mention in this short time; so a packet of material was delivered to each of your offices a few days ago. That information will help you understand the importance of this phenomenon to dental health.

The next discovery is that not a single dentist, physician, anthropologist, or anatomist has ever received the complete and correct anatomy of these muscles that would enable one to understand what is happening here.

There is a big void in our education and knowledge of this area. Not one of our great institutions is preparing or has ever prepared the students properly in the studies of this area. Seven anatomy books were researched and all combined do not have the necessary information that every person involved must have in order to do his best at his chosen profession. Since these muscles were not believed to be unusually significant, no one had ever bothered to figure out how they functioned and the effects of these functions on this area of the face. This lack of knowledge exists worldwide. This is an unacceptable situation which must be corrected as soon as possible. Since the anatomy is the most important factor and this knowledge is absolutely essential for one to understand what is occurring, the anatomy of the muscles of this area must be reviewed in minute detail and this chapter in the anatomy books must be rewritten.

I have attempted to contact many anatomists to try to get this condition corrected quietly within the profession, but with no success. It is not very flattering to the anatomy profession to have a dentist out in the field to have discovered something so important in their professional field. There is much resentment. I will be glad to furnish the details to anyone interested. You can imagine the reaction when I try to point out to the universities that something is missing in the education of the students.

These are serious charges and unfortunately true.

After no success with this section of the scientific community, I decided to try to get help from NIH. For three years I have been asking NIDR to let me present this material to them so that it could be studied, evaluated and a decision made as how best to handle this. For three years NIDR has refused to discuss this with me. If one cannot get help from NIDR in a case like this, to whom can we turn for help?

How NIDR can be so concerned about our dental health that it can request one hundred thirty million dollars for research yet refuse to discuss something that has such adverse effects on this dental health is beyond comprehension. All NIDR can suggest is that I attempt to have this material published so that I can have the benefits of review by my peers. That sounds good; but there is not a single reviewer who knows the necessary anatomy to render a valid appraisal of this phenomenon. I tried, and the comments by the reviewers were: "Your anatomy is provocative" and "It is not substantiated in literature." That is correct. My anatomy is meant to provoke or bring about the necessary changes in the anatomy books to ensure that everyone gets the complete and correct knowledge of this area; and if this material were in the literature, there would be no need for me to write about it.

Since NIDR would not discuss this with me, I wrote to the Surgeon General asking him to conduct a thorough investigation of the situation. My letter to him went to the same office in NIDR that has been refusing to discuss this with me.

This is an unusual situation. It is hard to believe that something so basic and so important has been overlooked by all, but it surely has happened. The professions have never been faced with anything like this before and probably never will again. This is too important to ignore, and the usual accepted manner to present new knowledge is not good enough. It takes too long. An editorial in a dental journal stated that it takes twenty-six years for a new idea to be accepted. This is more than a new idea, it concerns a major defect in our education and knowledge of this important area. Without this knowledge many adverse conditions in the mouth are unrecognized and undiagnosed. How can the best treatments for these conditions be performed under these circumstances? This phenomenon is too complex and too far reaching to explain in the short time available here. I will be glad to furnish and explain all the material at anytime to anyone who is interested.

A copy of my letter to the Surgeon General is in the material delivered to your offices.

NIH is in a perfect position to clarify this whole thing in a very short time. After the basics are understood, then all our efforts could be directed to studies and research to determine how to handle this phenomenon for the greatest benefits to the needy patients. This could be the most important project for NIH since flouridation: "What an opportunity to do something great for mankind!"

Therefore, I respectfully ask the Committee to request that NIH conduct a thorough investigation of the whole phenomenon.

Thank you kindly for any help in this matter.

Senator **WEICKER**. Now, let me just ask one question to make sure that I am understanding you correctly.

The matter that you want addressed to the Surgeon General relates to the facial muscles?

Dr. **FREDERICK**. It starts with the facial muscles, sir. No one has ever gotten the complete and correct anatomy of this part of the face [indicating].

Anatomy can be divided into two parts: the gross anatomy, which is a physical description of the muscle parts; and the functional anatomy, which is how they function.

That has never been figured out. It is very superficial, right under the skin, and no one thought it was important. Yet they are all very complex. Everybody wants to hurry and get it out of the way so that they can get to the important, deeper stuff.

That was the biggest mistake that was ever made. No one has ever realized the importance of this.

These muscles produce a constant pressure across the face, like an elastic curtain. It pulls back constantly. It can never relax day and night. That is the musculature that has reduced man from the snout and prehistoric man's face to where we are today.

Those pressures can never relax, from before birth throughout the entire life of the individual. It has a tendency to squeeze this part of the face into a smaller size.

It causes malocclusion, mistreatment, and makes the retention difficult, and causes a multitude of other dental problems, and has been totally unrecognized.

It is going to be with us until the end of time. It is basic and has to be recognized and its functions determined. Also the damage to the tissue because of this pressure has to be recognized.

It has never been, sir, never been studied.

In a few months, you are going to have a dental convention here in town, and if you would question them on their knowledge of anatomy, you would be surprised at the lack of knowledge in that particular area.

It causes many, many problems. Until that is correct, not a single university will be teaching correct and complete anatomy. It would allow us to so much better understand what is happening in this area.

Senator WEICKER. I thank you very much for your testimony, Dr. Frederick.

STATEMENT OF WILLIAM B. CLARK, PROFESSOR, DEPARTMENT OF ORAL BIOLOGY, SCHOOL OF DENTISTRY, UNIVERSITY OF FLORIDA, IN BEHALF OF THE AMERICAN ASSOCIATION FOR DENTAL RESEARCH

Senator WEICKER. Next is Dr. William Clark, associate professor, Department of Oral Biology, School of Dentistry, University of Florida, representing the American Association for Dental Research.

Dr. Clark.

Dr. CLARK. Thank you, Mr. Chairman. It is a pleasure to be here. I have recently been promoted to professor now.

Senator WEICKER. Congratulations. That's great.

Dr. CLARK. Thank you, sir.

NIDR has an extremely important function to the progress of dental research in the United States because it is the major source of funding for the dental research in this country.

As you know, it covers a multitude of oral conditions and diseases, and our goal is to learn how to prevent and control these diseases.

It is an enormous problem also, and many people fail to realize the cost in terms of dollars and lost man-hours.

Last year, or in 1986, Americans spent over $22 billion on dental services. While we are making progress in our effort to understand and prevent and control dental diseases, much still needs to be done.

However, I want briefly to point to some of the progress that has been made in the past several years.

A recent survey conducted with American adults between the ages of 18 and 65 showed that approximately 50 percent of these working adults had retained all of their teeth. Only 4.2 percent of these working adults had lost teeth.

Also, in the area of dental decay in children, the effects of water fluoridation and other preventive treatments, such as fluoride supplements and pit and fissure sealants, has saved the American public over $2 billion annually.

Although this news is welcome news, the problem is by no means over. For example, with older Americans, 65 years and older, 42 percent of these people have lost all their teeth.

So, this indicates that much needs to be done.

Also, as Americans retain their teeth longer, other problems associated with aging also come to the forefront.

I want briefly to talk about two advances that I think are important. I don't have time to talk about a lot of them.

One area that is particularly important to me, since I am involved in this area of research, is in the area of bacterial attachment, how bacteria attach to teeth, to other tissues in the mouth.

The importance of this field goes way beyond the scope of dental science. This field actually was developed in the early seventies by the appreciation that, in order to cause dental decay or peridontal disease, bacteria had to attach to the tooth surface or to other tissues in the mouth.

With this realization, it sparked interest in other areas of infectious diseases in this type of research, and now there is a whole field of infectious disease research that deals with mechanisms of attachment.

Also, in the area of AIDS, oral lesions have been identified as an early clinical manifestation of AIDS. Also, oral lesions in AIDS patients can be very painful, and can be the source of serious infections.

In the future, we need to build on the advances that we have made in treatments of peridontal disease. As Americans retain their teeth longer, we must increase our understanding associated with aging, such as root caries.

Another area that we need to continue to address in the future is the dentist-scientist program. We want to thank the committee for supporting this program over the past 4 years. This is a very important program, to continue to maintain the scientific community in the United States.

In our own group at the University of Florida, we have five postdoctoral researchers and only two of them are U.S. trained, U.S. citizens.

So, we need to continue this program.

Also, the research centers is another important program that we want to maintain.

I urge the committee to support the request of the AADR to provide $160 million next year to allow for a balanced research program in dental science.

PREPARED STATEMENT

I just want to remind you that the savings in treatment of dental caries in children alone is over $2 billion. So our request for $160 million is a fairly small investment for this kind of saving.

This concludes my testimony. I will try to answer any questions that you have.

Senator **Weicker**. Professor Clark, thank you very, very much for your testimony. I appreciate it.

[The statement follows:]

STATEMENT OF WILLIAM B. CLARK

Mr. Chairman and members of the Committee, my name is Dr. William B. Clark. I am an Associate Professor in the Department of Oral Biology in the School of Dentistry at the University of Florida.

I am appearing today on behalf of the American Association for Dental Research, of which I am a member. The members of the Association appreciate having this opportunity to present testimony regarding the 1989 budget for the National Institute of Dental Research.

Scope of Dental Science

The field of dental research is broad in that it covers a multitude of oral diseases which afflict the mouth, teeth, and jaws. Our goal is to learn how to prevent or control these diseases, so future generations need not lose a single tooth to disease.

Dental research is a broad field covering a multitude of oral diseases which afflict the mouth, teeth, and jaws. The approaches used to solve these problems include basic and applied research, with a strong emphasis on prevention.

Statement of Problem

Mr. Chairman, dental diseases are a major public health problem, and the cost of treatment consumes approximately 4.9% of total health expenditures. In 1986, the latest year for which information is available, Americans spent $22.5 billion for dental services.[1/] To this figure must be added the days lost from work, and lost productivity caused by pain and discomfort.

However, we are making progress toward reaching the goal I identified a moment ago. For example, a recent survey[2/] found that approximately 50% of the adult working population (ages 18 to 65) had retained all of their teeth, while only 4.2% had lost their teeth. In the 65 and older group, almost 42% had lost all their teeth.

While these findings point out that much work still needs to be done, it should be noted that when one compares the prevalence of edentulism in the current survey with that reported in a survey conducted in 1960-62[3/], the current survey shows

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[1/] Oral Health of United States Adults, National Findings; U.S.D.H.H.S., August, 1987, NIH Publication No. 87-2868.

[2/] Decayed, Missing and Filled Teeth Among Persons 1-74 Years, U.S.N.C.H.S., Series II, 1983.

[3/] Bureau of the Census (Note: Dental expenses, when viewed in terms of constant dollars, have remained level since 1981. This is another indication that dental research is paying a dividend to the public.)

less edentulism at every age interval. Thus, over the past two decades, more Americans have kept more of their teeth. For those senior citizens fortunate to have some or all of their teeth, the major problem confronting them is root surface caries, with 63% having about three lesions per person.

Advances in Dental Science

Members of the Committee, advances in dental research have contributed not only to better oral health for Americans, but also to an overall economic savings of over $2 billion per year.

Some of the current research findings include:

- Periodontal Diseases. Basic studies of oral ecology are revealing the mechanisms by which oral bacteria adhere to oral tissues and to each other to form plaque. This research could lead to ways of preventing such bacterial attachment.
- Caries. Root caries is an increasing problem for older Americans. Several researchers have developed both *in vitro* and animal models of root caries in order to study the formation and repair of lesions in the cementum (the mineralized tissue covering the roots of the teeth). Applications of topical fluorides were found to prevent most of these lesions.
- Restorative Materials. Restorative dentistry is being transformed through the use of new synthetic materials that can be bonded directly to tooth enamel with little need for drilling. Until recently, however, the new materials and methods have not been as successful in the treatment of lesions affecting dentin, the softer mineralized material underlying tooth enamel. Researchers are now perfecting techniques that have doubled and tripled the strength of synthetic bonds to dentin.
- Pain Control Studies. Studies aimed at elucidating factors in the etiology of temporomandibular joint pain are making use of new diagnostic technologies such as magnetic resonance imaging and arthrophonometry (an acoustic measuring device) to distinguish among various pathological conditions.

  New experimental models which mimic post-surgical pain as well as chronic inflammatory pain have been developed. These models, which reveal the nerve cells and naturally produced pain-suppressing chemicals involved in pain, could lead to novel therapies.
- AIDS. The human immunodeficiency virus (HIV) has been isolated from saliva, spurring research to discover if saliva plays a role in the history or

transmission of this disease. Certain oral lesions have been shown to be the first clinical manifestations of HIV infection. Studies to understand these lesions may help explain why some patients with HIV infection progress to having full-blown AIDS. Clinical studies of promising treatments of AIDS symptoms are currently under way.

Future Directions

Although we have come a long way in expanding the knowledge base, much still remains to be done. For example, research must be supported to:

- study the basic processes involving all the tissues of the oral cavity, including the lining of the mouth, the bone structures, and the connective tissues;
- build on the advances in the understanding of the natural history of periodontal diseases by developing new preventive and treatment techniques;
- encourage further genetic studies of craniofacial anomalies, such as cleft palate and cleft lip;
- expand studies of natural adhesive materials, such as the substance produced by the marine mussel, which may provide valuable leads to the design of man-made adhesives for teeth, bone, and even soft tissues;
- conduct additional studies of the relationship between nutritional factors and oral health and disease;
- study the role of the salivary glands and secretions in maintaining oral health and preventing disease; and
- explain the infections of the mouth which are seen in association with AIDS and develop effective means of preventing and treating them.

Dentist-Scientist Award

Mr. Chairman, we wish to thank this Committee for its support of the Dentist-Scientist program. The program is presently in the fourth year of its five-year plan. However, if the research momentum in dental science is to be maintained, then continued attention must be given to ensuring the future availability of a variety of investigators to staff dental schools and dental research institutes. Therefore, in order to continue the work you have begun, we respectfully request that an additional $1,900,000 be provided for this program in 1989.

Centers

The dental research community has found the center mechanism to be especially valuable in facilitating oral health research. Scientists in such fields as immunology and microbiology were drawn to oral health research through this mechanism, increasing the pool of research talent and accelerating the rate of progress. As knowledge increased about the etiology of the major dental diseases, categorical centers were established for specific research on dental caries and the periodontal diseases, to bring the same kind of multidisciplinary approach to these conditions. At present, we see great merit in maintaining both broad-ranging and categorical centers, and the committee is urged to provide for an additional twelve (12) centers.

Budgetary Needs

We are fully aware of the difficult budgetary pressures facing the Congress, and it is with this in mind that we respectfully request a funding level for the National Institute of Dental Research of $160 million for the fiscal year beginning October 1, 1988. This level will allow for a balanced research program in dental science, by supporting regular research grants, research centers, training, and intramural research.

It should be noted, Mr. Chairman, that the Association supports the NIH funding level of $8.2 billion recommended by the Ad Hoc Group for Medical Research Funding.

Also, Mr. Chairman, I would like to take the opportunity to address another program area which ensures the most effective implementation of dental research findings. This is the role of the National Center for Health Services Research and Health Care Technology Assessment. The Center seeks to create new knowledge and better understanding of the processes by which the health services are made available, and how they may be delivered more efficiently, more effectively, and at a lower cost. As such, the AADR shares a common goal with the Center, and we urge a $30 million appropriation for the Center.

This concludes my testimony. I thank you for this opportunity to testify, and I will be happy to answer any questions.

STATEMENT OF DIANE deROOS BASSAGE, AMERICAN DENTAL HYGIENISTS' ASSOCIATION

Senator **WEICKER**. Our next witness is Diane deRoos Bassage, representing the American Dental Hygienists' Association.

Ms. **BASSAGE**. Good morning.

Senator **WEICKER**. Good morning to you.

Ms. **BASSAGE**. On behalf of the American Dental Hygienists' Association, I would like to thank you for this opportunity to testify in support of fiscal year 1989 appropriations for the Department of Health and Human Services, especially the National Institute of Dental Research.

We have prepared a longer statement. But, in the interest of time, we have submitted that for the record and will summarize our recommendations.

Organized in 1923, the American Dental Hygienists' Association represents 30,000 members across the country, dedicated to assuring the highest level of preventive dental care.

Originally formed to develop communication and mutual cooperation among hygienists, ADHA today serves as an advocate for dental hygienists at the Federal, State, and local levels.

Mr. Chairman, dental hygienists today play a vital and cost-effective role in the delivery of oral health services, similar to the evolving role initially played by registered nurses in the delivery of medical services.

Dental hygienists perform numerous preventive and therapeutic services. Dental hygienists are involved in direct patient care, including patient education, review of medical and dental histories, formulation of health promotion activities, and initial therapy recommendations.

We have made significant strides in achieving good dental health in this country. In recent years, we have witnessed a 50-percent decrease in tooth decay overall, and one-third of American grade school children are now cavity free.

The most recent national survey on adult dental health conducted by the National Institute of Dental Research indicates that America's teeth are in better shape than ever. The tremendous progress that has been made in the dental health of children has begun to carry over into the middle aged population.

However, a great deal remains to be done, especially among our elderly.

The NIDR survey found that seniors had a 63-percent incidence of root caries, compared with a 21-percent increase among employed adults.

In addition, 42 percent of seniors surveyed were missing all their teeth, while only two had retained all of their permanent teeth.

Continued research at NIH is critical to the future of prevention. The National Institute of Dental Research has helped to revolutionize our knowledge and provision of dental health care.

Through NIDR sponsored research, we have: Identified the major cause of certain forms of dental caries; validated the importance of fluoride in oral health regimens; been able to work toward a vaccine against dental caries; improved adhesive sealants to protect teeth from the ravages of dental caries; identified the link between good nutrition and good oral health; and demonstrated the importance of education and promotion activities in assuring good oral health.

Despite these successes, and last year's increase in funding for the Institute, funding for NIDR has not been commensurate with the research need, as reflected in the NIDR long-range research plan for fiscal years 1985 through 1989.

While the administration's fiscal year 1989 budget plan recommends a modest increase for NIH and NIDR, it is simply not enough to maintain current research momentum.

NIH funding must increase by over 14 percent in fiscal year 1989 to achieve the same level of effort as in 1988. The ADHA endorses a budget of $160 million for NIDR, a budget that would allow NIDR to proceed with timely implementation of its long-range plan.

This recommendation is consistent with those of the ad hoc coalition for medical research funding, which has recommended $8.2 billion for all of NIH in the upcoming fiscal year.

In addition, ADHA recommends that the appropriation for the Centers for Disease Control should include funds to allow the Director of the Center for Prevention Services to allocate $1.3 million for the dental disease prevention activity [DDPA].

The DDPA is a vital support mechanism which provides a national focus for the control and prevention of oral diseases, such as dental caries, periodontal disease, and oral cancer.

PREPARED STATEMENT

The 30,000 members of the American Dental Hygienists' Association appreciate the important contribution this committee has made by improving the quality and availability of dental health care services throughout the country. We sincerely hope that this committee will continue to support preventive health programs as the most reasonable approach to long-term reduction in national health care expenditures.

Again, thank you for the opportunity to present our views.

Senator Weicker. Diane, thank you very much for your testimony.

We appreciate it.

[The statement follows:]

STATEMENT OF DIANE deROOS BASSAGE

The American Dental Hygienists' Association ("ADHA") very much appreciates this opportunity to present its recommendations regarding FY 1989 Appropriations for the Department of Health and Human Services ("HHS"), and in particular, the National Institute of Dental Research ("NIDR"). Organized in 1923, ADHA represents 30,000 members across the country dedicated to assuring the highest level of preventive dental care. Originally formed to develop communication and mutual cooperation among hygienists, ADHA today serves as an advocate for dental hygienists at the federal, state and local levels.

Today, dental hygienists play a vital cost-effective role in the delivery of oral health services, similar to the evolving role initially portrayed by registered nurses in the delivery of medical services. Dental hygienists perform numerous preventive and therapeutic services. As contributing professionals in the delivery of oral health care services, dental hygienists are involved in direct patient care, including but not limited to, patient education, review of medical/dental histories, formulation of health promotion activities, assessment of soft tissue health, prophylaxis, x-rays, soft tissue curettage, root planing, local anesthesia, and initial therapy recommendations.

THE STATE OF AMERICAN DENTAL HEALTH

The role of these activities in achieving optimal dental health is impressive. We have been witness to a fifty-percent decrease in tooth decay overall, and one third of American grade-school children are now cavity free. Indeed, research scientists suggest that elimination of most major dental diseases may be possible within the lifetime of oral health professionals now practicing. The most recent national survey conducted by the National Institute of Dental Research ("NIDR") regarding adult dental health indicates that America's teeth are in better shape than ever, though some population groups still are in need of special dental attention. The survey results also suggest that the tremendous progress that has been made in the dental health of children has begun to carry over into the middle-aged population.

Yet a great deal remains to be done, especially among our elderly. The survey found that seniors had a 63 percent incidence of root caries, compared with a 21 percent incidence among employed adults. In addition, 42 percent of seniors surveyed were missing all their teeth, while only 2 percent had retained all permanent teeth.

Indeed, we are still far from the ultimate goal of total prevention:

- Overall, Americans are spending $20 billion a year for treatment of their dental and oral problems;
- Americans lose 32 million days of work due to dental problems, costing the American economy $3 billion in lost wages. Amazingly, this economic statistic does not even include losses in productivity;
- 23 million Americans are missing all of their teeth;
- Despite reductions in dental cavities, the average American child has at least one cavity lesion by age 8; 4 by age 12, and 11 by age 17.

Counterbalancing these gloomy figures, though, is the promise of prevention. Research has shown that at least one form of cavities (coronal caries which attack the crowns of teeth) is preventable. Moreover, the National Institute of Dental Research ("NIDR") Long-Range Research Plan for FY 1985-1989 has stated that, "fluoride regimens and adhesive sealants, combined with good oral hygiene and wise eating habits, can prevent tooth decay in normally healthy individuals." Herein lies the true value of the hygienists' mission: as the lead advocates, spokespersons and educators in preventive oral health care, we can do something about preventable disease today.

NATIONAL INSTITUTE OF DENTAL RESEARCH ("NIDR")

Founded in 1948, NIDR, one of the 12 major biomedical research institutions within the National Institutes of Health, has helped to revolutionize our knowledge and provision of dental health. In identifying the causes of preventable dental diseases and the appropriate strategies to combat these maladies, NIDR has led the way. Through NIDR sponsored research, we have:

- identified the major cause of certain forms of dental caries;
- validated the importance of fluoride in oral health regimens;
- been able to work towards a vaccine against dental caries;
- improved adhesive sealants to protect teeth from the ravages of dental caries;
- identified the link between good nutrition and good oral health; and
- demonstrated the importance of education and promotion activities in assuring good oral health.

Despite these successes, and last year's 7 percent increase in funding for the Institute, funding for NIDR has not been commensurate with the research need. Although the Long-Range plan indicates a budget need of $174.5 million for NIDR in FY 1989, plan implementation has been slowed, in part due to recent budgetary restrictions which have affected all of NIH. Thus, a budget for FY 1988, which would allow NIDR to proceed with timely implementation of the Long-Range Plan, would provide NIDR with $160 million for the upcoming fiscal year.

We are pleased that the Administration has recognized the cost-effectiveness of biomedical research in proposing a modest increase for NIH and NIDR. The Administration recommends an increase for NIDR of $4,029,000 over the 1988 appropriated level. This level would allow the Institute to fund 125 new and competing research project grants at an average cost of $168,000 for a total of approximately $21 million. This would represent an increase of 21 grants and an increase of 3 percent in average project costs.

Despite this welcome change in the Administration's thinking, the recommended increase of 5.8 percent for NIH falls substantially short of the 14 percent increase necessary to achieve the same level of effort as in FY 1988. For this reason, funding of $160 million would enable NIDR to maintain current services and also expand research in areas of particular importance and potential.

CENTERS FOR DISEASE CONTROL

The Dental Disease Prevention Activity ("DDPA") funded through the Centers for Disease Control ("CDC") is a vital support mechanism for state dental health programs. The DDPA provides a national focus for the control and prevention of oral diseases such as dental caries, periodontal disease, and oral cancer. As the national leader in dental disease control and prevention, the DDPA provides consultation, training, promotional and educational support, disease surveillance, and other technical services to state and local governments and other professional, educational, and citizen organizations.

Although the DDPA is not a line item in the President's FY 1988 budget proposal, the CDC appropriation should include funds to allow the Director of the Center for Prevention Services to allocate $1.3 million for the DDPA. In FY 1988 the DDPA's budget totaled approximately $1 million. ADHA's recommendation would allow the DDPA to resume and enhance its mission in education and health promotion - a mission which recently has been sorely neglected.

CONCLUSION

The 30,000 members of the American Dental Hygienists' Association appreciate the contribution this Committee has repeatedly made to improving the quality and availability of dental health care services throughout this nation. We hope that the Committee will continue to support preventive health programs as the most responsible method for long-range reduction in national health care expenditures. In this regard, we hope Committee members will seriously consider these specific funding recommendations. Again, we appreciate the opportunity to present our views.

Summary of Recommendations:

The American Dental Hygienists' Association ("ADHA") recommends that, for FY 1989, the National Institute of Dental Research ("NIDR") receive an appropriation of $160 million. ADHA also supports funding levels of $1.8 billion for the National Cancer Institute ("NCI") and $240 million for the National Institute on Aging. These funding requests are consistent with the overall recommendations for the National Institutes of Health ("NIH") of the Ad Hoc Coalition for Medical Research Funding which recommends $8.2 billion for NIH overall in the upcoming fiscal year. ADHA strongly endorses the Ad Hoc Committee Recommendations. In addition, the Congress should indicate its desire that the Director of the Center for Prevention Services at the Centers for Disease Control ("CDC") fund the Dental Disease Prevention Activity ("DDPA") at $1.3 million through the Director's discretionary budget.

STATEMENT OF WILLIAM E. ALLEN, D.D.S., ASSOCIATE EXECUTIVE DIRECTOR, AMERICAN DENTAL ASSOCIATION

Senator **Weicker**. Last, but not least, is Dr. William Allen, the associate executive director of the American Dental Association.

Dr. Allen, it's nice to have you here.

Dr. **Allen**. Thank you, Mr. Chairman. I am glad to be here once again, appealing for your support for the National Institute of Dental Research.

We would just like to touch on a few things, not to repeat what the other witnesses have said.

We think there are three areas of research that are exceedingly important. One is research on the elderly, which is the fastest growing segment of our population, and the problems that they are going to face in terms of their dental needs, particularly in the area of periodontal disease and root caries.

We also are concerned about the prevention aspect of this activity. We think it is still the best method of controlling costs, that is, to prevent disease rather than to try to cure it once it is there.

As an example of the kind of research that is being done at NIDR, I think it is also important to point out that, as you all know, for some years dentistry was associated with pain. Hopefully, we have overcome that problem and can deliver dental care without pain.

But it has opened the door and provided an initiative for the study of pain. The Institute is doing some very interesting studies in the causes of pain, including back pain and headaches, and such things as that, which I think is very interesting, and will lead to a great deal of advancement in the field of pain control.

It is also interesting to point out that a recent study on AIDS and the role of saliva, the Institute developed this study which shows that saliva is an inhibitor of the AIDS virus.

As we all know, saliva does not normally contain antiviral elements. So this is a specific inhibitor in the saliva, and so we are going to be following this study very, very carefully.

The support for the Dental Science Award is very high on our list of priorities. It is $1.9 million. We really want to encourage more young professionals to go into the scientific area.

Along with that, as has been mentioned before by other people testifying this morning, it is important to upgrade the research facilities that are out there. So, we hope that the committee will support this.

We are also urging the support of the $160 million amount.

PREPARED STATEMENT

We are very grateful to the committee and to you, in particular, Senator Weicker, and to your staff for the support you have given us over the years.

That concludes my testimony.

Senator **Weicker**. Dr. Allen, thank you very much for your testimony.

[The statement follows:]

STATEMENT OF WILLIAM E. ALLEN

Mr. Chairman and Members of the Subcommittee. I am Dr. William Allen, Associate Executive Director of the American Dental Association and Director of the ADA's Washington Office. I am here today to speak in support of those initiatives critical to the dental health of the public that rely on public funding for their continued effectiveness.

Dental Research: Paramount among these is dental research, most of which has been carried out over the last four decades by the National Institute of Dental Research. The continuing success of the dental profession in reducing caries is principally the result of research. It lowers the annual national expenditure for dental care by approximately eight percent. That is $2 billion saved each year, more than the cumulative funds appropriated for NIDR throughout its 40-year history.

This is a single example of the success of dental research, success which may confidently be projected for the future with appropriate support. Work is continuing on natural repair and regeneration of teeth and gums and into the cause of root surface caries, efforts that will protect the teeth of older Americans, especially the aged, our nation's fastest growing population.

Research continues for future control and eventual elimination of periodontal disease, which is the single greatest cause of tooth loss in people over 35.

Synthetic restorative materials, developed through dental research, are now being modified to treat lesions in the dentin, the softer layer beneath the enamel.

Therapies to control pain are being explored through new experiments into post-surgical and chronic inflammatory pain.

Studies of craniofacial anomalies are producing findings important not only to clinical dentistry but also to prevention of bone malformation in fetuses.

The critical role of dental research in addressing the enormous public health challenge posed by Acquired Immune Deficiency Syndrome is heightened by the infection's earliest manifestations often being lesions in the mouth. Clincal studies of experimental treatments of AIDS symptoms are being conducted at NIDR.

The dental profession and the public at large owe the Congress a debt of gratitude for its foresight in supporting dental research over the years. But much is still to be accomplished in oral health promotion, research training, development of research facilities and equipment, and the NIDR Centers Programs.

As a result of findings from the recent National Survey of the Oral Health of Employed Adults and Seniors, NIDR is planning to mount a major program to promote oral health and disease prevention in adults and older Americans. The Association encourages increased support for this vital activity.

Another area of critical importance is research training. The Dentist-Scientist Award Program is proving to be an important, most successful initiative designed to create a critical number of well-trained research-oriented dentists. A 1985 Institute of Medicine (IOM) study of the need for biomedical researchers concluded that the numbers currently being trained each year will fall significantly short of the projected need for scientists. The IOM study emphasized that NIDR is essentially the only sponsor for the training of dental investigators and recommended that the number of training positions for dentist-scientists be increased by 320 by the year 1990. In FY 1986, only 90 National Research Service Award trainees were dentists. Even with the 25 graduates per year expected from the Dentist-Scientist Award Program, the number of dental investigators being trained will only be about one-third the number recommended by the IOM.

The Association recommends that $8.4 million in training funds be appropriated to move dental research forward toward the IOM goal.

Equally compelling is the problem of finding funds for replacement of equipment. The Association recommends that additional funds be appropriated for the small instrumentation grant program and the shared instrumentation grant program.

The Association supports the concept of Core Center Grants for NIDR and recommends that the number of research centers permitted be increased. This would help expand the research capabilities of institutions that have already made a commitment to strengthen their research activities by providing core support for independent researchers as they become members of focused research teams. It will also have an impact on the future training of dentists.

In summary, the American Dental Association joins with the American Association for Dental Research in urging appropriations for NIDR of $160,380,000.

Prevention: Dental practice in the United States today is epitomized by disease prevention. The Committee is to be congratulated for its recognition of the value of the Dental Disease Prevention Activity established within the Centers for Disease Control in 1975. DDPA has provided national leadership and professional expertise in community water fluoridation, the single most effective preventive oral health measure in our nation's history.

In the past four years, the Activity has sought to duplicate its fluoridation success in an expanded program of implementation, monitoring and surveillance of a broad range of dental disease prevention activities, prominent among them, the conduct of surveillance and epidemiological studies to determine the prevalence of the human immunodeficiency virus in dental health care workers from needlesticks or sharp instrument injuries, and to measure the significance of oral conditions which may provide evidence of HIV infection. Submitted with this statement is Infection Control: Fact and Reality, A Training Program for Dental Offices, published by the Association and furnished to every dental office in the United States. The substance of this publication was drawn in large measure from the work of DDPA. To continue these critical activities in 1989, DDPA should be appropriated $1.2 million.

Equally important, in the Association's view, is for the Committee to provide increased visibility to DDPA through the specific identification of its funding as an individual line item.

Data Collection: Further, the Association urges that $70 million be appropriated for the National Center for Health Statistics in order that it may continue to conduct statistically sound activities that embrace all major health sectors.

Finally, the Association wishes to thank the Committee for its direction last year to the Secretary, Department of Health and Human Services, to initiate a study into appropriate goals and priorities in dental health research, education, prevention and service, as well as the most appropriate methods of coordinating dental health activities within the department. The dental profession eagerly awaits the completion of this study and submission of recommendations to the Congress.

We appreciate the Committee's consideration of our views.

PREPARED STATEMENT OF BARBARA IGLEWSKI

Senator **WEICKER**. The subcommittee has received a statement from Barbara Iglewski of the American Society for Microbiology which will be placed in the record at this point.

[The statement follows:]

STATEMENT OF BARBARA IGLEWSKI, PH.D., PRESIDENT, AMERICAN SOCIETY FOR MICROBIOLOGY

My name is Barbara H. Iglewski and I am President of the American Society for Microbiology (ASM). I am also Chairman of the Department and Professor of Microbiology and Immunology at the University of Rochester School of Medicine and Dentistry. The ASM is the largest single biological life science society in the world with an active membership of over 34,000. Many of these individuals are engaged in biomedical research and are recipients of awards administered by the National Institutes of Health (NIH). On behalf of the ASM, I wish to thank the Chairman of the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies for the opportunity to express the views of the ASM on the fiscal year 1989 budget for the NIH.

Although the Administration's fiscal 1989 budget request for the NIH represents a 5.4% increase over fiscal 1988 for non-AIDS activities and appears to be a more reasonable proposal than recent budget submissions, the ASM believes that this budget is inadequate for a number of reasons. First, the Administration's budget will require a reduction of 291 fewer new and competing research project grants in fiscal 1989 than in fiscal 1988 and 692 fewer new and competing grants than were funded in fiscal 1987, an 11% decline. Second, the proposed budget will perpetuate and, in fact, intensify to unprecedented levels, the amount of downward negotiation, or cuts, in the funding levels of grants that have been recommended by NIH study sections and councils. For the scientific community, a major impact of the budget request is that both noncompeting and new and competing NIH research project grants would be paid on average at 9.9% to 13.3 % below study section recommended levels in fiscal 1989. Such severe reductions, which come on top of several years of inadequate funding for research project grants, will have a real effect on slowing the capability of investigators to carry out the research represented by the funded grants. Significant cutbacks of support for investigator-initiated research project grants, even for a one-year period, would have a long lasting effect and should be avoided if at all possible.

With these considerations, and in view of the critical role of NIH in fundamental health-related research and at the leading edge of biotechnology, the ASM supports the recommendations of the Ad Hoc Group for Medical Research Funding, which proposes a budget of $8.2 billion for the NIH in fiscal 1989 (or $8.4 billion if funding for facilities is included). Simply to fund fully, at study section recommended levels, the proposed number of noncompeting grants and the same number of new and competing research project grants that will be funded in fiscal 1988, an estimated 6052, would require $7.6 billion in fiscal 1989, or over $400 million more than requested by the Administration. Although this level of funding would maintain NIH programs at their current operating level, it would not permit NIH to take full advantage of the many scientific opportunities that will ultimately lessen suffering and loss of human potential and would be covered by the proposed budget of the Ad Hoc Group.

While we are fully aware that Congress must make difficult budgetary choices, we urge that the NIH budget be protected against irreparable damage to medical research and we ask that you maintain the vitality and productivity of our national medical research enterprise even during the current fiscal crisis.

Basic Research and Acquired Immune Deficiency Syndrome (AIDS)

The war against AIDS will require research in a wide range of areas of scientific investigation and an expanded talent pool. Very little of the AIDS funding is being committed to predoctoral training. This is an extremely short-sighted view which will have negative effects on our ability to conquer this horrible disease. Funding for AIDS research and training should be broadly defined and should include areas of science which could provide the knowledge base for future advances in AIDS research. Over the next several years, we expect that for both scientific and political reasons, there will be large increases in funding for AIDS research. We support these enhanced efforts and recommend that new funds be used in a broad scale way for the support of the highest quality research to increase our fundamental understanding of this disease. We would like to point out that despite the generous appropriations for AIDS related-research, that only approximately one-third of the approved AIDS research proposals are being funded.

The ASM recommends against consolidating authority for all AIDS funding in the Office of the Assistant Secretary for Health (OASH) because we believe funding for AIDS research decisions should remain at the institute level. This proposal appears counter to the expressed desire of the Congress to shorten the length of time between application and funding of AIDS grants. It would add an unnecessary layer of bureaucracy which would simply extend the time required and would surely reduce the amount of actual AIDS research that is accomplished.

Non-AIDS Research

Not only does the National Institute of Allergy and Infectious Diseases (NIAID) take the lead role in research on AIDS, but it also is one of the main supporters of original research in molecular genetics and immunology that is on the leading edge of modern biology. We are concerned that the award rate for non-AIDS approved grants at NIAID is estimated at only 30% for fiscal 1989 and the projected payline of 140 is one of the lowest at NIH. This level of funding for NIAID non-AIDS grants is dangerously low, especially, in view of the many infectious diseases which still need significant research efforts. The appearance of new and newly recognized infectious diseases--such as toxic shock syndrome, Legionnaire's disease, Lyme arthritis and AIDS--forces a realization that devastating infectious diseases are not a thing of the past.

Training

The available data indicate that the current supply of the appropriate types of bioscientists does not seem to be keeping up with a growing demand particularly by the biotechnology industry. Recruitment of some of academia's best scientists by biotechnology firms also creates a growing shortage of academic researchers to educate the next generation of scientists. Based on an informal survey of the recruiting experiences of Microbiology Department Chairmen in Medical Schools conducted in 1986, there is continuing evidence that highly qualified scientists are becoming difficult to find in selected fields, such as molecular biology.

Two of the most pressing problems facing the scientific enterprise are the growing shortfall in the numbers of predoctoral Ph.D. trainees and the inadequate level of research training stipends. NIH is not supporting enough predoctoral trainees to maintain a full pipeline. A greater than 50% faculty turnover is estimated by 1995 and to fill the need created by these openings, NIH should be training a larger number of predoctoral students at this time. To attract the best students and remain competitive, we support increases to raise the stipend level. Current stipends are totally inadequate and represent approximately two-thirds of the actual stipends paid to most graduate students, which means that each training slot really is a matching position rather than a full grant from the government. We wholeheartedly support the Ad Hoc Group's recommendation of $313 million for NIH training which assumes an increase in pre- and postdoctoral stipends as recommended by NIH.

We would like to add that we believe it is important to control tuition costs as a part of training grants. In this regard the Society supports the NIH Committee on Payment of Tuition recommendation of a two-tiered flat tuition and fee allowance in lieu of payment of full tuition and fees. We believe this recommendation should be given serious consideration.

Infrastructure

Additional funding for infrastructure needs is particularly acute with respect to addressing new space and equipment requirements and safe containment facilities for AIDS research and improvement of animal care facilities. With the increasing public sensitivity to the use of animals in research, improvement of animal facilities constitutes protection against the threat that the progress of research would be severely impeded by the inabilit to use animals where necessary. We also believe biomedical research would benefit from the addition of $5.6 million for resource and research projects, supported by the Division of Research Resources (DRR) Laboratory Animal Scienc (LAS) Program, which are important to improving the health and availability of research animals. We recommend an additional $700,000 to support the postdoctoral training of more laboratory animal veterinarians to meet the increasing demand created by new animal welfare policies.

SUBCOMMITTEE RECESS

Senator **WEICKER**. We thank all who have attended.

The subcommittee will stand in recess until tomorrow morning at 9 a.m.

[Whereupon, at 11:20 a.m., Tuesday, May 24, the subcommittee was recessed, to reconvene at 9 a.m., Wednesday, May 25.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1989

WEDNESDAY, MAY 25, 1988

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:03 a.m., in room SD-192, Dirksen Senate Office Building, Hon. Daniel K. Inouye presiding.

Present: Senators Inouye and Weicker.

NONDEPARTMENTAL WITNESSES

Senator INOUYE. This morning the subcommittee will continue with the fifth of 9 days of hearings with public witnesses, with testimony focusing on the programs funded by the subcommittee and the 14 related agencies.

During these several sessions, the subcommittee will hear testimony from approximately 225 witnesses, the largest number yet to be heard by the subcommittee in a single year. Because of the large number of witnesses, we must request that each witness keep their oral testimony brief. I would like to assure all of you that your full statement will be made part of the printed record.

Incidentally, at today's session we will be receiving testimony from 24 witnesses.

STATEMENT OF HON. SPARK MATSUNAGA, U.S. SENATOR FROM HAWAII

Senator INOUYE. Our first witness this morning is a very distinguished member of the U.S. Senate, my colleague from Hawaii, the Honorable Spark Matsunaga.

Welcome, Senator.

Senator MATSUNAGA. Thank you, Mr. Chairman.

I greatly appreciate this opportunity to testify in support of funding for the native Hawaiian provisions of the Older Americans Act of 1987. As chairman of the Labor and Human Resources Subcommittee on Aging, which has legislative jurisdiction over the Older Americans Act, I commend you and the members of this subcommittee for considering an increase in funds for older native Americans in fiscal year 1989.

Title VI of the Older Americans Act was intended by Congress to be the Nation's principal vehicle for funding services to older native Americans. Designed to meet the unique cultural and social needs of elderly native Americans, title VI authorized grants for food and nutrition services, health education and promotion, and other services targeted at this very needy minority population.

In reauthorizing the Older Americans Act last year, Congress made a number of significant changes which should greatly improve the delivery of services to older native Americans. For the first time we included native Hawaiians in title VI of the act, which previously covered only American Indians and Alaskan Natives.

As a consequence, public and nonprofit private organizations which serve older native Hawaiians are now eligible to receive grants under title VI. In addition, Congress removed a longstanding prohibition which had prevented the recipients of services under title VI of the act from receiving services under title III, providing grants for State and community programs on aging. Congress also mandated area agencies on aging to conduct outreach activities to older native Americans in areas where there is a significant population of older native Americans.

In view of the fact that title VI has never been adequately funded, it is most important that native American senior citizens be able to receive at least supplemental services under title III. Finally, Congress mandated the establishment within the Administration on Aging of an Office for Native American Programs headed by an Associate Commissioner. The new Associate Commissioner would administer grants provided for native Americans, including native Hawaiians, evaluate the adequacy of outreach under titles VI and III of the act, collect and disseminate information, and develop research plans relating to native American aging, coordinate activities between other Federal departments and agencies to ensure the continued improvement of services to elderly native Americans and in general, act as an advocate for older native Americans.

Mr. Chairman, during consideration of these amendments by the Subcommittee on Aging, we found that over one-third of older native Hawaiians live in poverty. They have an average life expectancy of 10 years less than any other ethnic group in the State of Hawaii, and rank lowest in 9 of 11 standard health indices for all ethnic groups in Hawaii. Perhaps saddest of all, we found that elderly native Hawaiians are frequently unaware of social services available to them and do not know how to go about seeking assistance. I strongly believe that we have taken the first step toward remedying this situation by including native Hawaiians among older native Americans eligible for specific assistance under the Older Americans Act.

However, this clear expression of congressional intent will do no good unless adequate funds are provided for the title VI grants program. Since native Hawaiians will receive no funds unless title VI is funded at a higher level than it was in fiscal year 1988, I urge you, Mr. Chairman, and members of this subcommittee, to provide at least $8.5 million for title VI programs in fiscal year 1989.

I further urge that the Appropriations Committee include report language which would affirm our intention that there should be an Office for Native Americans Program within the Administration on Aging. The strong advocate and administrator which we envisioned should greatly improve the administration of title VI grant programs and help make the needs of elderly native Americans much more visible.

Again, Mr. Chairman, thank you for this timely hearing on the needs of older native Americans and for your continued dedication to the needs of older native Hawaiians.

Thank you very much, Mr. Chairman.

Senator INOUYE. Thank you very much.

If I may put on my different hat as chairman of the Select Committee on Indian Affairs, the committee that has jurisdiction over native Americans, which includes native Hawaiians I wish to thank you for the extraordinary work that you have done as chairman of the Subcommittee on Aging.

Your work has been recognized with great gratitude by the leaders in Indian country, and I am certain the native Hawaiians in Hawaii are fully aware of the work you have done in that area.

As to the appropriations that you have suggested, let me assure you that this subcommittee will do everything possible, but as you are aware, we are presently in the process of determining the budgetary limits, and we are now in a stage where we must reconcile the differences between the House and the Senate. Frankly, I would hope that we will lean in favor of the House side because the House is a bit more liberal in its appropriations for projects of this nature, but I can assure you that as a member of this subcommittee, I will do everything possible.

Senator MATSUNAGA. Thank you.

Senator INOUYE. The statistics you have noted are tragic, and I think something should be done to change that cycle.

Senator MATSUNAGA. Thank you, Mr. Chairman, and I wish to commend you for the work and the role you have played in furthering not only the position of native Americans, but particularly native Hawaiians, and I commend you for it.

Senator INOUYE. Thank you very much.

Senator MATSUNAGA. Thank you.

STATEMENT OF TERENCE A. ROGERS, PH.D., PROFESSOR OF PHYSIOLOGY, AND FORMER DEAN, JOHN A. BURNS SCHOOL OF MEDICINE, UNIVERSITY OF HAWAII, HONOLULU, HI

Senator INOUYE. Our next witness is the dean of the John A. Burns School of Medicine, the University of Hawaii, Dr. Terence A. Rogers.

Dr. Rogers, it is always good to see you, sir.

Dr. ROGERS. Thank you, sir.

I would emphasize that I was until recently the dean, and I am here representing my successor, the acting dean, Dr. Gulbrandsen.

The testimony, Mr. Chairman, is about the Pacific Basin Medical Officers Training Program which is designed to train indigenous people of Micronesia and American Samoa to be primary care physicians in their own countries, and a program tailored to the realities of their educational background and the future resources of their States.

Through the good offices of this subcommittee, we have received $3.7 million out of a total of $10 million originally approved for the 10 year life of the program. These current appropriations will permit the program to continue through calendar year 1989, and so my brief testimony this morning is in the nature of a progress report. We are not requesting funds at this time. But we will be back.

Senator INOUYE. You had better put in your bid now.

Dr. ROGERS. I have received advice.

We are very pleased that the first two classes are off and running, and we are in the process of selecting a third class, and I know for yourself and only for those others who have been to these truly far flung islands, to recognize the difficulties and the enormous challenge of developing high grade medical training down there.

It is going extraordinarily well, mainly because we have a vigorous young faculty there who are extremely practical minded, we understand the multiplicity of languages there and understand the social structure of the islands.

The participating States, the director of health or the minister of health is a member of an advisory board. They meet with us and their table of candidates for admission, and then we play sort of a poker game in which students are admitted to the program roughly on a pro rata basis of the population of each State.

The main thing is, it is working. The Micronesians and American Samoans recognize that this is something that will actually continue to work once these men and women are trained.

In summary, this program is part of an overall strategy of the University of Hawaii to address the health manpower shortage in Micronesia, pinpointed by the U.S. Public Health Service, in prudent and practical ways, consistent with the wishes of the people of that region.

PREPARED STATEMENT

It is going well, and the program enjoys the support of the various governments. The support of this subcommittee is truly appreciated by all of those of us from the University of Hawaii and the Micronesian and American Samoan leadership.

[The statement follows:]

STATEMENT OF TERENCE A. ROGERS

This testimony concerns the Pacific Basin Medical Officers Training Program (PBMOTP) which is entirely funded by the United States at the initiative of this Subcommittee, and conducted by the John A Burns School of Medicine of the University of Hawaii. The testimony is presented by Terence A. Rogers, Ph.D., Professor of Physiology and the former Dean of the John A. Burns School of Medicine, at the request of the current Acting Dean, Christian Gulbrandsen, M.D., and on behalf of the faculty of the Program and the Micronesian and American Samoan Health leadership who have themselves testified to your Subcommittee about this Program.

Through the good offices of this Sub-Committee we have received $ 3.7 Million out of the total of $10 Million originally approved for the ten year life of the Program. Current appropriations will permit the program to continue through calendar-1989, and so this testimony is in the form of a progress report rather than a request for funds in the current cycle.

The purpose of the Pacific Basin Medical Officers Training Program is to train the next generation of physicians to meet the acute shortage in the present and former American flag territories of the Pacific Basin, a shortage dramatically documented by a study conducted by USPHS Region IX in 1984. The Program trains indigenous people of Micronesia and American Samoa to provide acute primary care at an advanced level, to provide preventive medicine leadership, and to train and supervise other

[illegible] the Board of Advisors who, through their own admissions committees, recommend students for admission on an approximately pro rata level for their populations. The overall goal is to train 100 or more Micronesian and American Samoan physicians in the decade for which the program is planned.

The PBMOTP curriculum is a community-oriented, problem-and competence-based approach designed for entering students who have limited study skills and relatively disadvantaged educational backgrounds. In recognizing the problems in acute care and public health of the area, the curriculum is practical and appropriate to regional resources. The format is faculty-intensive instruction in which appropriate basic sciences are integrated from the outset into the clinical and public health training. Emphasis is given to those preventive and curative skills which are critical in the Pacific Basin.

Community Medicine is stressed in the curriculum since in many of the jurisdictions it has been neglected in favor of centralized, hospital-based care which is reactive to otherwise preventable diseases and, therefore, not cost-effective. We would also note that in some jurisdictions as much as 50% of the entire health budget has been used for referrals of a relative handful of patients to Hawaii or the U.S. Mainland.

A long-term objective of the Program is to develop a primary care infrastructure by training primary care physician specialists who, as the next generation of indigenous health leaders, will develop and implement health care systems that are appropriate and responsive to the real needs of the region.

The first three years of training are in Pohnpei; a fourth year will be spent at one of the large Pacific Basin hospitals. This is being

[illegible] from the Rockefeller Institute. The fifth and final year of training will be spent in each student's home jurisdiction, fulfilling training objectives certified by faculty members serving as in-country program Medical Education Coordinators.

Special features of the Program are determined by some unusual characteristics of our students and the Pacific, and these features illustrate the intense practicality of our faculty's approach. A pervasive problem in the Pacific Basin is the multiplicity of languages and even though English is a common language, our students' facility in English is frequently a limiting factor to their study skills, which would also be predicted from the educational disadvantages addressed by the Program. Accordingly, the core of a first year program in Study Skills is an intensive "survival course" in English as a Second Language (ESL) developed by the ESL Department of the University of Hawaii. This course is tailored to individual students' needs as assessed by preliminary testing. The improvement in performance from better English comprehension and structured training in study skills has been most gratifying. Also, since the early part of the clinical training is entirely within the State of Pohnpei, the language of the patients is Pohnpeian, which is incomprehensible to students from other parts of the Pacific. Accordingly, in the second year all students and faculty (except those from Pohnpei) receive a "crash course" in the Pohnpeian language delivered by former Peace Corps language facilitators. This obviates the need for an interpreter at every clinical encounter and greatly improves rapport with the patients.

Twenty three students entered the first class in January 1987 and 20 successfully completed that year and are embarked on their second year of

[illegible]

are women and [illegible] are married. Recruitment for the third class has already begun and will continue through August 1988. In October the Advisory Board will meet on Guam with the Program Faculty to select the class to begin their studies in January 1989.

As noted, the first three years of instruction are in Pohnpei and, through the cooperation of the Pohnpei State Government, the Program uses the hospital, rural clinics and dispensaries for teaching. The hospital has also allocated some excellent classroom and audio-visual facilities space. A former construction camp, located adjacent to the hospital was renovated with funds appropriated by this committee. This unpretentious and "down home" facility provides vital dormitory space, classrooms, laboratories and offices.

The U.S. Public Health Service assigns National Health Service Corps doctors to Micronesia, and through an agreement between USPHS Region IX and the John A. Burns School of Medicine those NHSC doctors participate in the teaching of students in the Program consistent with their main clinical responsibilities.

In summary, the development of this Program is part of an overall strategy of the University of Hawaii to address the health manpower shortage in Micronesia in prudent and practical ways consistent with the wishes of the people of the region. It is going well and enjoys the support of the various jurisdictions. The support of this Sub-Committee has been truly vital and is deeply appreciated by those of us from the University of Hawaii, and also by the Micronesian and Samoan leadership.

Senator **Inouye**. I wish to, through you, commend the University of Hawaii Medical School for taking the initiative in this type of program. Most Americans are not aware of the unique health delivery problems experienced in Micronesia and Samoa. First of all, not too many American physicians are pleased to spend their time out there. Second, the type of ailments and problems and diseases are rather unique. One does not find the type of skin diseases that are commonplace out there or the large number of diabetes patients, et cetera.

What you are doing is something that should have been done a long time ago, and of all the many programs that we are responsible for, I think this is the biggest plus, and we have done this for pennies.

I commend you, sir.

Dr. **Rogers**. Thank you, sir.

Senator **Inouye**. Thank you very much.

STATEMENT OF MYRON B. THOMPSON, TRUSTEE, KAMEHAMEHA SCHOOLS, BERNICE PAUAHI BISHOP ESTATE

Senator **Inouye**. Our next witness is the distinguished trustee of the Kamehameha Schools and the Bernice Pauahi Bishop Estate, Mr. Myron B. Thompson.

It is always good to see you.

Mr. **Thompson**. It is nice to be here with you.

Thank you very much, Mr. Chairman and members of your committee.

My name is Myron Thompson, and I represent the Kamehameha Schools, a private educational trust working to assist native Hawaiians reach parity in education in Hawaii and the Nation as a whole.

I am here this morning for four reasons: first, to thank this committee for providing funds for native Hawaiians in the past. Because of this committee, we will now be able to address the severe hearing loss problems evident in native Hawaiian preschool children. Also, Mr. Chairman, we thank you for your continued support for family based education centers, a program initiated by Senator Weicker and yourself.

My second reason for being here is to restate that the needs we presented to your committee in 1984 remain intense. However, the provisions in Public Law 100-297 will make a difference and assist in our effort to reach parity.

Third, to share our priorities with you.

And finally, to ask your consideration for funding in mental health research which I believe is directly related to native Hawaiians' ultimate success.

Public Law 100-297 authorizes five programs, family based education centers, elementary reading and language arts, the gifted and talented, higher education and special education.

Since your committee has a full report on the educational status of Hawaiians, I will focus on sharing our thoughts on priorities for funding today.

We, along with others, believe that prevention is critical. The national business-led Committee for Economic Development stated in its 1987 report "Children in Need: Investment Strategies for the Educationally Disadvantaged," that programs for disadvantaged children which stress developmental learning and social growth, including quality preschools, represents, and I quote, "a superior educational investment for society."

Funding for family based education centers are therefore our highest priority.

I also advocate higher education programs for financial and counseling support, providing the advantages of college and professional degrees, and for the gifted and talented, making sure potential is identified and challenged.

Our next priority is reading and language arts programs designed for Hawaiian children. It is our desire to reach at least 20 public schools with such programs.

The final priority for funds for Public Law 100-297 is in the area of special education.

Mr. Chairman, this brings me to our last request that I wish this committee to consider for funding. In 1984 you asked the Department of Health and Human Services to conduct a comprehensive native Hawaiian health needs study. Five task forces reported. The mental health group found that native Hawaiians, compared to the statewide population, is at risk in virtually every mental health indicator. For example, young native Hawaiian males are the most at risk for suicides and drugs, and are more likely to be admitted to State facilities for violent and abusive acts. Furthermore, native

Hawaiians avoid use of existing mental health services; instead, they will participate in interpersonal conflict resolution processes which are vestiges of ancient healing practices. Our mental health professionals who, for the most part, are nonnative Hawaiians, dismiss these practices as being based on superstitions. I have disagreed with this premise, but I do not have the hard evidence to support this point of view. I believe that an intensive professional inquiry into the principles underlying the ancient mental health practice of ho'oponopono, in English, to set to right, will elicit basic similarities within present-day psychotherapeutic theory. As such, the extensive present day underground practice of ho'oponopono can be legitimatized, described and put into teachable units for use by our mental health practitioners.

In addition, our present day elders, who are providing ho'oponopono in its present form can be assisted to sharpen their skills based on clear, documented theory.

For this and other mental health applied research needs may we suggest $750,000.

PREPARED STATEMENT

The support of this committee is needed for native Hawaiians, once an independent and self-sufficient people. We wish to regain our place in Hawaii and the world, and Mr. Chairman and members of your committee, native American Hawaiians thank you for your past and present interest.

Mahalo nui lo.

[The statement follows:]

STATEMENT OF MYRON B. THOMPSON

My name is Myron Thompson. I represent Kamehameha Schools, a private educational trust working to assist Native Hawaiians statewide reach parity in Hawaii and the nation.

I am here for four reasons:

- First, to thank the committee for providing funds for Native Hawaiians in the past. Because of this committee, we will now be able to address the severe hearing loss problems evident in Native Hawaiian pre-school children. Also, we thank you for your continued support for Family-based Education Centers, a program initiated by Senator Weicker.
- My second reason for being here is, to restate that the needs which we presented to your committee in 1984 remain intense. However, the provisions in Public Law 100-297 will make a difference and assist in our effort to reach parity.
- Third, to share our priorities with you.
- And finally, to ask your consideration for funding in mental health research, which I believe is directly related to Native Hawaiians' ultimate success.

Public Law 100-297 authorizes five programs - Family-Based Education Centers, elementary reading and language arts, gifted and talented, higher education, and special education.

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We, along with others, believe that prevention is critical. The national business-led Committee for Economic Development stated in its 1987 report, Children in Need: Investment Strategies for the Educationally Disadvantaged, that programs for disadvantaged children which stress developmental learning and social growth (including quality preschool . . .) represent "a superior educational investment for society."

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For this and other mental health applied research needs may we suggest $750,000?

The support of this committee is needed for Native Hawaiians. Once an independent and self-sufficient people, we wish to regain our place in Hawaii and the world. Mr. Chairman and members of the committee, the Native American Hawaiians thank you for your past and present interest. Mahalo Nui Loa.

Senator INOUYE. All right, thank you very much, Mr. Thompson.

I wish to commend the Bishop Estate for taking the initiative in pressing for these educational aid programs. I realize that your responsibility as trustee is to the estate and to the beneficiaries of the estate, but I commend the estate for going out beyond the parameters of the beneficiaries of that school and concerning yourselves with the problems of native Hawaiians in the community in general.

In case the people here are not aware, we have already benefited from the extraordinary work carried out by the Bishop Estate. For example, the fact that today Gallaudet University has a branch operation on the University of Hawaii Manoa Campus can be traced to the work of the Bishop Estate.

The Bishop Estate, through its investigations, noted a high incidence of deafness and hearing loss problems among native Hawaiian children, and as a result, the U.S. Government appropriated a small sum of money to conduct a professional study, a study which indicated, to our horror, that over 60 percent of native Hawaiians who were 4 years old were either deaf or suffering from measurable hearing loss.

It appears that there is a great correlation between hearing loss and poverty, and we are now trying to cope. The Gallaudet University presence on our campus will now make it possible for our teachers to first, recognize and identify those with hearing loss, and second, do something about it.

So there are many thousands of young men and women in Hawaii who are now benefiting from the leadership that has been demonstrated by the Bishop Estate, and more specifically, by you, sir.

Thank you very much.

Mr. THOMPSON. Thank you, Mr. Chairman.

And thank you to the committee for giving us that opportunity.

Senator INOUYE. Let me assure you that the request you have made, now totaling over $10½ million, is a very high priority of ours sir.

Mr. THOMPSON. Thank you.

STATEMENT OF DR. EDWARD J. KORMONDY, CHANCELLOR, UNIVERSITY OF HAWAII AT HILO

Senator INOUYE. Our next witness is the chancellor of the University of Hawaii at Hilo, Dr. Edward J. Kormondy.

Mr. Chancellor, welcome. It is good to see you.

Dr. KORMONDY. Mr. Chairman and members of the committee, thank you for this opportunity to speak on title IV, section 4006 of the Elementary and Secondary Improvement Amendments of 1988. This section of the act provides for the establishment of a Native Hawaiian Gifted and Talented Center at the University of Hawaii at Hilo for demonstration projects designed to address the special needs of gifted and talented native Hawaiian youngsters and to provide support services to their families to enable such students to benefit from the project.

As several of the previous speakers have noted, over the past 200 years, native Hawaiians have experienced substantial declines in population and most severe sociocultural disintegration. While all of these conditions cannot be ameliorated or corrected by education, many can be, provided there is sufficient leadership in the Hawaiian community itself. Such leadership is often reflected in role models of success in the business, industrial, governmental, and professional communities, roles that are increasingly dependent on the attainment of postsecondary education.

However, native Hawaiians are grossly underrepresented in higher education, comprising only 9 percent of the total University of Hawaii student body in the fall of 1987. Given the pool of Hawaiians eligible, present enrollments are only 40 percent of what would be expected.

Efforts to recruit Hawaiian students into college depend to a large extent on individual faculty and staff efforts, coupled with special minority-oriented programs. These elements explain the significantly higher percentage of native Hawaiian students at the University of Hawaii, Hilo, namely 18.5 percent. The identification and nurturing of gifted and talented native Hawaiians will result in native Hawaiians moving along the educational spectrum in greater numbers, and thereby short circuiting their socioeconomic disintegration.

Justification for the gifted and talented center being located at the University of Hawaii at Hilo rests on a number of factors, among them, Hawaiians constitute the largest ethnic group of high school students on the Island of Hawaii. Hawaiians will dominate the elementary schools in but a few years. There is a broad spectrum of Hawaiian communities on the big island from rural to semiurban. There are experienced teachers who have worked with the gifted and talented youngsters in the public school system.

The university itself has in place a leadership program for talented Hawaiian college students, the experience of which can be brought to bear at elementary and secondary levels.

Through discussions with educators regarding existing gifted and talented programs, including one that concluded this past Friday and Saturday, we have verified that native Hawaiians have not been adequately represented in these gifted and talented programs. Standard selection criteria appear to select out these minority students whose gifts and talents are not measured by traditional means, similar to the experience of native Americans and other minority groups.

The need, then, is for us in Hawaii to develop a model for the education of the gifted and talented that will not only capitalize on the diversity of talents of Hawaiian young people, but will inevitably benefit all elementary and secondary minority students.

PREPARED STATEMENT

In summary, Mr. Chairman, your support for this appropriation will be a means of enabling more native Hawaiians to assume their rightful role in contemporary society.

I thank you.

[The statement follows:]

STATEMENT OF DR. EDWARD J. KORMONDY

Mr. Chairman and Members of the Committee, I wish to thank you for the opportunity to present testimony before the Subcommittee in support of Fiscal Year 1989 funding for programs authorized by the Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988. My testimony will focus on one program of particular interest to Native Hawaiian gifted and talented students.

Title IV, Section 4006 of the Act provides that the Secretary of Education shall provide a grant to, or enter into a contract with, the University of Hawai'i at Hilo for the establishment of a Native Hawaiian Gifted and Talented Center at the University for demonstration projects designed to address the special needs of Native Hawaiian elementary and secondary school students who are gifted and talented and to provide those support services to their families that are needed to enable such students to benefit from the project.

A Brief Profile of Native Hawaiians

Over the past 200 years, Native Hawaiians have experienced a substantial decline in population and severe socio-cultural disintegration. Depression, loss of identity, alienation, poor self-concept, fear of failure, fear of success, hopelessness and helplessness are a few of the recurring descriptions of a significant portion of the Native Hawaiian population.

Reviews of Native Hawaiian health and educational needs show a significant portion of Native Hawaiians suffer from pervasive vulnerability to various problems that include high rates of alcohol and substance abuse, high suicide rates among young adults, poor educational performance in the public schools, low enrollment in higher education, high rates of family violence, and the majority of inmates in Hawai'i prisons.

In addition, Native Hawaiians occupy a low socio-economic position in the State of Hawai'i. They have the lowest median income among the four major ethnic groups and represent the highest proportion of the population in low status occupations.

Whereas not all of these conditions are resolvable by improvement in attainment at all levels of the educational spectrum, many are. And, given cultural traditions, many would be resolved, or at least alleviated, provided there were sufficient leadership in the Hawaiian community itself.

Such leadership is often reflected in role models of success in the business, industrial, governmental, and professional communities, roles that are increasingly dependent on the attainment of post-secondary education.

Native Hawaiians and Higher Education

However, the fact is that Hawaiians are grossly underrepresented in higher education and, most notably, at the University of Hawai'i which comprises the public higher education institutions in the State in which most Hawaiians live.

Hawaiians constituted only 9 percent of the total University of Hawai'i student body in the Fall of 1987, ranging from 5.0 percent at the University of Hawai'i at Manoa to 18.5 percent at my institution. Professor Kiyoshi Ikeda, of the University of Hawai'i at Manoa, indicates that, given the pool of Hawaiians available and eligible for higher education, present enrollments are only 40 percent of what would be expected.

Demographic data show that in Hawai'i, Hawaiians are the largest ethnic group in the age cohort of 18 years of age and younger. This translates to Hawaiians having the largest available population for college eligibility.

The data also indicate that among Hawaiians 25 years of age and older who have attended college, only 35 percent actually obtained a bachelor's degree as compared to 60 percent of Chinese, Caucasians, and Japanese in the same age group. There is thus a significant pool of adult Hawaiians who have not completed a college degree.

At present, efforts to recruit Hawaiian students depend to a large extent on individual faculty and staff efforts. The University of Hawai'i at Hilo's higher proportion of Hawaiian students as compared to the UH system as a whole is the result of a committed faculty and staff who offer a variety of programs that appeal to different students. Among these programs are Reaching Out For Success In Nursing, Health Careers Opportunity, Minority Biomedical Research Studies, and Hawaiian Studies certificate and baccalaureate degree programs.

A recent unpublished doctoral dissertation by Dr. David Sing, of the University of Hawai'i at Hilo, reports that when underprepared Hawaiian students are placed in a classroom environment that is closely aligned with values and practices associated with Hawaiian home values, a significant positive change in attitude toward education, school officials, classmates, and themselves results.

The Need for a Native Hawaiian Gifted and Talented Center

The intent of Section 4006 is right on target. Its various components befit the pattern of programs that have been initiated elsewhere regarding black and native Mexican students with which I had considerable experience at the California State University at Los Angeles. Implementation of the Native Hawaiian Gifted and Talented Center is a proven approach to undergirding an overall enhancement of the educational status of Native Hawaiians and correcting the foregoing dire statistics on underdeveloped potential.

In the urge to be accessible and to be all things to all people, and given the resource allocations required to address the very considerable responsibility of assisting so very many underprepared students, there is a segment in America's educational programs that too often gets left out--the gifted and the talented. In the significant national study "A Nation at Risk," the National Commission on Excellence in Education chaired by David P. Gardner, now president of the University of California, noted, "The Federal Government, in cooperation with States and localities, should help meet the needs of key groups of students such as the gifted and talented, (a group which) includes both national resources and the Nation's youth who are most at risk."

This group of students, the report further notes, "may need a curriculum enriched and accelerated beyond even the needs of other students of high ability."

Fortunately, Title IV, Section 4006 specifically addresses this population of Hawaiian students, calling for a demonstration program to address the special needs of gifted and talented elementary and secondary school students.

Justification for the Center to be Located at the University of Hawai'i at Hilo

Mr. Chairman, I strongly support this demonstration project for Gifted and Talented Hawaiians to be located on the Island of Hawai'i and at the University of Hawai'i at Hilo for a number of reasons, among them:

1. Hawaiians constitute the largest ethnic group of high school students on the Island of Hawai'i.
2. In 1985, 51 percent of all births in Hilo were Hawaiian. This population will dominate the elementary schools in but a few years.
3. There is a broad spectrum of Hawaiian communities on the Big Island, from rural ones in which traditional Hawaiian traditions are practiced to semi-urban, more or less assimilated middle class groups.
4. There is an existing gifted and talented program at Waiakea High School in Hilo whose staff would constitute an experienced resource for a program directed specifically to Hawaiian students.
5. Hilo High School has been designated as a magnet school in the performing arts, an attraction for students gifted in those fields.
6. The University of Hawai'i at Hilo Hawaiian Studies faculty were instrumental in developing and implementing a program for pre-schoolers called Punana Leo, meaning "language nests," the objective of which is to preserve the Hawaiian language. Instruction is entirely in Hawaiian for these tots, and talent is encouraged to mature.
7. The University of Hawai'i at Hilo has in place a Leadership Program for talented Hawaiian college students, the activities of which include Hawaiian language and culture, as well as

leadership development, training, and internship opportunities.

In addition to these salient reasons, the presence of a higher education institution on the Big Island is an invaluable adjunct to successful gifted and talented programs as demonstrated elsewhere, serving to provide resource personnel, college level classes and activities for gifted and talented students, and leadership models from among its students, faculty, and staff.

Initial Stages in the Development of the Native Hawaiian Gifted and Talented Center

Over the past five months, we have been gathering information and consulting with various educators and administrators in the State regarding gifted and talented programs in Hawai'i and elsewhere. Through these discussions, a number of factors relevant to enhancing the education of Hawaiian students have been identified.

It is the consensus of many teachers and resource specialists in the field of gifted and talented education in Hawai'i that Hawaiian students have not been adequately represented in these special programs. While there has also been universal agreement that there are many Hawaiian students whom teachers would label "gifted," our local experts have suggested that Hawaiian students, like students from other minority groups, are not identified as gifted and talented for a number of reasons. First, the standardized selection criteria that are used to select students for gifted education programs often limit the diversity of students that have "gifts and talents" which are not measured by traditional means. Second, the emphasis in many programs for gifted and talented students is on the academic achievement areas such as math and sciences, which, according to many national researchers in education limits the range of minority students who meet the performance measures for selection. Finally, the combined social, economic, and health barriers for Hawaiians in particular have affected the ability of students to successfully achieve in education.

All of the above conditions point to the need for us in Hawai'i to develop a model for gifted education that will not only reflect the diversity of talents that Hawaiian young people, Native Americans and others possess, but which will inevitably benefit all elementary and secondary students. Some of the unique aspects of the Hawaiian culture provide a rich resource to be integrated into gifted and talented activities education, including language, ancient and contemporary Hawaiian arts and crafts, and leadership.

In addition, such activities can address the recent trend in education that examines various learning styles by which we may enhance the educational achievement of not only Hawaiians but many other students.

Next month, The University of Hawai'i at Hilo will be sponsoring a working seminar where a selected group of educators, administrators, parents and other community members from throughout the State will begin to address relevant issues in the education of gifted and talented Hawaiian students. The seminar is envisioned as a beginning effort to identify the strengths and barriers in enriching the education of Hawaiian students.

Concluding Statement

In summary, Mr. Chairman, I indicate my strong support for this appropriation as a means of enabling more Native Hawaiians to assume their rightful role in contemporary society.

Senator **Inouye**. Mr. Chancellor, I thank you very much for your testimony, and I would like to commend your campus for taking the initiative in the specialized training, leadership training for native Hawaiians. It was because of this type of initiative that the committee decided that the Hilo Campus should be selected for this demonstration project.

I think two institutions should be singled out, yours and the University of Hawaii Medical School, for the initiatives taken to recruit, train, and serve native Hawaiian students. You pointed out that the University of Hawaii campus has 5-percent representation from native Hawaiians. Yours is about 18½, isn't it?

Dr. **Kormondy**. That is correct.

Senator **Inouye**. The medical school has an enrollment of 10-percent native Hawaiians, which is double that of the University of Hawaii Manoa Campus, and this was done by active recruiting, just as you have done, and I believe that this may be the way to do it, to go out into the community and seek out potential leaders.

For that I am certain native Hawaiians are most grateful to you, sir.

Dr. **Kormondy**. Thank you.

Senator **Inouye**. And everything will be done to support this appropriation.

Dr. **Kormondy**. Good. Thank you, Mr. Chairman.

STATEMENT OF DR. ANTHONY J. MARSELLA, VICE PRESIDENT FOR ACADEMIC AFFAIRS, UNIVERSITY OF HAWAII AT MANOA

Senator **Inouye**. Out next witness is the vice president for academic affairs of the University of Hawaii at Manoa, Dr. Anthony J. Marsella.

Dr. Marsella, welcome, sir.

Dr. **Marsella**. Thank you, Senator Inouye. I am very grateful for the opportunity this morning to testify before you on behalf of the University of Hawaii, and especially our university's faculty and students of Hawaiian ancestry.

I have two purposes. First is to describe some of our recent achievements, and second is to call your attention to some of our growing needs.

For much of its 80-year history, it is unfortunate that the University of Hawaii was relatively unresponsive to the educational needs of the native Hawaiian residents of our State. However, during the past 2 years we feel we have made significant progress toward assisting the native Hawaiians to assume their rightful role in our State. Among the more positive events which have occurred include the establishment of a new School of Hawaiian, Asian and Pacific Studies, the establishment of a Center for Hawaiian Studies as 1 of our 10 regional study areas, the assignment of five new faculty and staff positions to the Center for Hawaiian Studies; the creation of a full-time director of Hawaiian studies; the approval of nine new courses in Hawaiian studies; the development of plans for certificate, master's degree, and doctor of philosophy degree programs in Hawaiian studies; the appropriation of more than a quarter of a million dollars by the Hawaii State Legislature to develop plans for a new building for the Center for Hawaiian Studies; the establishment of cooperative teacher training programs among the Kamehameha Schools. the department of education, and the University of Hawaii; the inauguration of a Hawaiian Leadership Program at Hilo, to which you referred earlier; and the assignment of two faculty positions to the department of anthropology for the study of Hawaiian archeology.

In addition, we have inaugurated a very broad based recruitment program to attract more native Hawaiian students to attend the University of Hawaii. This recruitment program includes both efforts to identify talented Hawaiian youth as early as the seventh grade, and efforts to provide financial and academic support for those Hawaiians interested in pursuing educational careers in such fields as social work, nursing, medicine, psychology, and the biological sciences.

For example, among the many NIMH-sponsored programs in which we participate are the research centers in minority institutions, the Minority Biomedical Research Program, the minority access to research careers, and the Minority High School Student Research Apprenticeship Program.

Yet, even as I speak of our successes, I am compelled to point out the need for additional local and Federal support. As you have noted, although Hawaiian people constitute more than 20 percent of our State's population, only 5 percent of our student body at our major campus is of native Hawaiian ancestry, and only 20 of the more than 1,200 faculty on a major campus can be considered native Hawaiian. Clearly this is unacceptable. We need additional funds for service, training, and research programs. For example, we have formed a center for the study of minority higher education at the university, and we hope with this center to investigate problems of learning and learning styles among native Hawaiians.

In addition, we must increase the number of native Hawaiians in the teaching professions. We must increase the native Hawaiians' postsecondary education aspirations, we must more effectively monitor native Hawaiian student progress, we must initiate faculty-mentor programs for native Hawaiians, we must continue efforts to support curriculum, research and service programs directed toward improving our understanding of Hawaiian culture and history, we need to develop longitudinal study data bases on student outcomes. We need to conduct studies on native Hawaiian student attitudes, and we need to expand collaborative relationships with other public and private agencies.

The costs for these studies and programs will be great, but it is clear that the economic and personal cost which is currently being exacted from the native Hawaiian people is far greater. We are witnessing the demise of an entire culture, and unless something is done to attenuate the course of events, the Hawaiian people and the culture which they have openly offered to the world will be lost.

PREPARED STATEMENT

We ask that you carefully consider the needs of the native Hawaiian people and all indigenous people in our land when you reach your budgetary decisions. With your support, the future of the Hawaiian people can be filled with opportunity and hope.

We wish to thank Senator Inouye for all that you have done for the Hawaiian people and for all the people of our State.

Thank you very much.

[The statement follows:]

STATEMENT OF DR. ANTHONY J. MARSELLA

My name is Anthony J. Marsella. I am the Vice President for Academic Affairs of the University of Hawaii. I am grateful for this opportunity to testify before you today on behalf of the University of Hawaii and especially our University's faculty and students of Hawaiian ancestry.

The University of Hawaii is the public university of the State of Hawaii. It enrolls more than 45,000 students across seven community college (Leeward, Kapiolani, Honolulu, Windward, Maui, Kauai, Hilo), a four year college (Hilo College), a two year upper division college (West Oahu College) and a comprehensive University which offers bachelors degrees in 85 areas of study, Masters degrees in 84 areas of study, Ph.D. degrees in 48 areas of study, and professional degrees in numerous areas of study (e.g., medicine, law, education, library science, nursing, public administration, business administration, tropical agriculture, engineering, social work, public health, and travel industry management).

Of the more than 3300 four year colleges and universities in the United States, the University of Hawaii at Manoa (i.e., our State's comprehensive university) ranks 70th in terms of total external research funds. Our library of two million volumes ranks 46th and our journal holding rank 26th in the nation. More than thirty of our departments rank within the top fifty in the United States. We are especially proud of our astronomy program (the finest land-based astronomy program in the country), our ocean sciences program, and our programs in international business, foreign language training (we teach more than 44 different languages per year), and tropical agriculture. Our travel industry management program is considered by many to be the best in the United States.

The University of Hawaii also has the only programs in the United States in Korean Studies, Philippine Studies, Pacific Island Studies, Hawaiian Studies, and Soviet/Asian-Pacific Studies. And we are the site of one of our nation's two peace research institutes and one of the national centers for health promotion and disease prevention. These programs are just a few which hold national and international ranking but they will give you a sense of the excellence which exists at the University of Hawaii.

However, even as I speak of our many talents and achievements, I must also speak of our problems. The University of Hawaii is a land grant and sea grant university which was founded in 1907 in Honolulu, Hawaii. For much of its eighty year history, the University was unresponsive to the educational needs of the Native Hawaiian residents of our State. Indeed, it is unfortunate that many other sectors of our State also seemed to ignore the needs of the Native Hawaiian people. But, in recent years, this situation has changed and there have been many signs of progress. For example, in 1978, The Hawaii State Constitution was changed to mandate the State Government to: (1) Promote the study of Hawaiian culture, history, and language; (2) Provide for a Hawaiian education program consisting of language, culture, and history in all public schools.

At the University of Hawaii, the inauguration of a new University administration in 1986 brought a greater sensitivity to the problem of the Native Hawaiian people. This has resulted in the implementation of a broad-based action program directed toward the establishment of new organizational structures and new recruitment and retention programs to improve the educational status of Native Hawaiians.

In early 1986, a university-wide task force of Native Hawaiian students and faculty was charged to develop a long-term education program. The report of this task force, entitled Kau ("to go beyond" or "to transcend"), has provided the foundation for a number of new cooperative efforts among the University, the Native Hawaiian community, and various state agencies. Among the positive efforts are the following:

1. The establishment of a School of Hawaiian, Asian, and Pacific Studies (SHAPS).

2. The establishment of a Center for Hawaiian Studies as one of ten regional study centers within SHAPS.

3. The assignment of five new faculty and staff positions to the Center for Hawaiian Studies.

4. The creation of a full-time director of Hawaiian Studies.

5. The approval of nine new coures in Hawaiian Studies.

6. The development of plans for Certificate, Master's Degree, and Doctor of Philosophy degree programs in Hawaiian Studies.

7. The appropriation of more than a quarter million dollars by the Hawaii State Legislature in 1988 to develop plans for a new building for the Center for Hawaiian Studies.

8. The establishment of cooperative teacher training program among the Kamehameha Schools, the State Department of Education, and the University of Hawaii. This training program emphasizes techniques for working with Native Hawaiian students and other high-risk student groups and is based on the knowledge developed from the Kamehameha Early Education Program at the Kamehameha Schools.

9. The inauguration of a Hawaiian Leadership Program at Hilo College to explore strategies for development of Native Hawaiian leaders.

10. The assignment of two faculty positions to the Department of Anthropology for the study of Hawaiian Archeology.

11. A recruitment program to attract more Native Hawaiian students to attend the University of Hawaii. This recruitment program includes both efforts to identify talented Hawaiian youth as early as the seventh grade and efforts to provide financial and academic supports for those Hawaiians interested in pursuing educational careers in such fields as social work, nursing, medicine, psychology, and the biological sciences. Among the many NIH sponsored programs in which we participate are the following:
    A. The Research Centers in Minority Institutions (RCMI);
    B. The Minority Biomedical Research Support Program (MBRS);
    C. The Minority Access to Research Careers Program (MARC);
    D. The Minority High School Student Research Apprenticeship Program (MHSAP).

    All of these programs and numerous other locally supported programs serve to increase the representation of Native Hawaiians in the health, science, and education professions and also give them the opportunity to deal directly with problems and disease which impact the Native Hawaiian people.

Yet, even as I speak of our successes, I am compelled to point out our need for additional local and federal support. For example, although Native Hawaiian people constitute more than twenty percent of Hawaii's population, only five percent of our student body at our major campus is of Native Hawaiian ancestry. And, only twenty of the more than 1200 faculty at our major campus can be considered Native Hawaiian. Clearly, this is unacceptable!

We need additional funds for both service, training and research programs. For example, we have formed a Center for the Study of Minority Higher Education. This research unit will investigate various issues and problems regarding higher education needs of Native Hawaiians. What are the most effective instructional methods? What is the optimum personality and academic profile for instructors? What type of classroom setting will best interface with Native Hawaiian learning styles? How can we teach Native Hawaiian students through outreach programs such as interactive television? These are some of the questions that need examination and that will require financial support. In addition, we must develop new programs which will: (1) Increase the number of Native Hawaiians in the teaching professions at all levels; (2) increase Native Hawaiian post-secondary education aspirations; (3) more effectively monitor Native Hawaiian student progress through the educational system; (4) initiate faculty mentor programs for Native Hawaiians to provide more personal contact with successful role models; (5) continue to support efforts to support curriculum, research, and service programs directed toward improving our understanding of Hawaiian culture and history; (6) develop longitudinal study data bases on student outcomes; (7) conduct studies of Native Hawaiian student attitudes; (8) expand collaborative relationships with other public and private agencies involved with Native Hawaiians.

The support which has thus far been provided by the federal government through the Maternal and Child Health Program of the NIH and through the various programs of the Department of Interior are deeply appreciated and promise to make a significant impact upon the challenges we are facing. However, more must be accomplished. The cost for these studies and programs will be great but it is clear that the economic and personal cost which is currently being exacted from the Native Hawaiian people is far greater. We are witnessing the demise of an entire culture and unless something is done to attenuate this course of events, the Hawaiian people and the culture which they have openly offered to the world will be lost. We ask that you carefully consider the needs of the Native Hawaiian people and all indigenous people in our land when you reach your budgetary decisions. With your support, the future of the Hawaiian people can be filled with opportunity and hope. Thank you very much and aloha.

Senator **Inouye**. Thank you very much, Dr. Marsella.

I think your testimony was very candid in noting that for the first many years, the University of Hawaii was not responsive to the educational needs and leadership training needs of native Hawaiians, and in many ways this parallels the history of our trust relationship with the Indians of this country.

Let me assure you that, as chairman of the Indian Affairs Committee, everything will be done to make certain that the United States honors, recognizes, and carries out its trust responsibilities with native Americans.

Dr. **Marsella**. Yes, sir.

Senator **Inouye**. I am pleased, naturally, and I am certain native Hawaiians are pleased that the University of Hawaii is finally taking the initiative and the responsibility of participating in this training endeavor of future leaders of Hawaii.

I think it should be noted that the Governor of Hawaii today is a product of the University of Hawaii and the law school there.

So we hope from these programs we will train future Governors of Hawaii and future U.S. Senators and Representatives.

I thank you very much.

Dr. **Marsella**. Thank you very much, Senator Inouye.

STATEMENT OF MOSES KIALI, CHAIRMAN, BOARD OF TRUSTEES, OFFICE OF HAWAIIAN AFFAIRS

Senator **Inouye**. Our next witness was scheduled to be the dean of the School of Public Health at the University of Hawaii, Dr. Jerrold Michael, but I have been advised that because of certain emergencies, Dean Michael is not able to be here with us, and so representing Dean Michael is a very distinguished citizen of the State of Hawaii. He is the Chairman of the Office of Hawaiian Affairs, Mr. Moses Kiali.

Mr. Chairman, it is good to see you, sir.

Mr. **Kiali**. Senator Inouye, members of the committee, I am Moses Kiali, chairman of the board of trustees of the Office of Hawaiian Affairs. The Office of Hawaiian Affairs is a semiautonomous agency created through an amendment to the Constitution of the State of Hawaii in 1978. The Office's mission is for the betterment of conditions of native Hawaiians.

I am here today to testify on behalf of Dr. Jerrold Michael, dean of School of Public Health of the University of Hawaii, who is unable to be here today.

I would like to thank you, Senator Inouye, and Dr. Michael, for allowing me this opportunity to testify on such an important subject matter. Dr. Michael asked me to bring to your attention two important points that are stated in his testimony. First, to ask for your continued support of the Federal Pacific Health Initiative, a group called together by Governor John Waihee in an effort to address the pressing health problems of Hawaii's neighboring Pacific nations.

Second, Dr. Michael further asked for your continued support of several national prevention centers and one international prevention center.

On behalf of the Office of Hawaiian Affairs, I would like to summarize the plight of native Hawaiians. Several studies have demonstrated that native Hawaiians suffer significantly higher unemployment than other residents of the State of Hawaii, higher rates of poverty and incarceration, the highest infant mortality, the lowest life expectancy, higher incidence of cancer and alcoholism, higher rates of respiratory conditions such as asthma, higher rates of personality disorders and mental retardation, and higher suicidal rates.

Furthermore, native Hawaiians have the highest rate of academic and behavioral problems in schools, lower academic achievement, higher participation rates in social welfare programs, lower rates of enrollment in institutions of higher learning, and higher rates of truancy and dropouts than other ethnic groups in the State.

Moreover, native Hawaiians have higher rates of social problems including assaultive acts and antisocial behavior, alcohol and narcotics use, child abuse and neglect, and residence in correctional institutes.

From the information I have just given you, native Hawaiians need your continued support.

In conclusion, since 1982 I have been invited to attend the South Pacific Commission meetings in which issues such as health, education and economic development have been discussed. Through these meetings I have come to realize that health, education and economic problems of native Hawaiians are similar to the health, education and economic problems of other Pacific Islanders.

To this end, the Office of Hawaiian Affairs shares the same concern of the School of Public Health at the University of Hawaii, that is, to provide health promotion and prevention services to native Hawaiians and our brothers and sisters in the Pacific Basin.

PREPARED STATEMENT

The Office of Hawaiian Affairs looks forward to working with the School of Public Health and other Federal, State, and private agencies in Hawaii and the Pacific Basin.

On behalf of Dr. Michael and the Office of Hawaiian Affairs, I thank you for this opportunity to present testimony to this committee.

Mahalo also.

[The statement follows:]

STATEMENT OF MOSES KIALI

Mr. Chairman, a special process is underway in the Pacific Basin that may be unique in the history of our country. In the operation of the Pacific Health Promotion and Development Center, the Governor of the State of Hawaii has committed the health community of our State to a health collaboration with the other island nations that make up the U.S.-related territories of the Pacific.

Using the resources of the Federal Government under Sec. 301 of the Public Health Service Act (which we have come to call the Federal Pacific Health Initiative) as a focus, Governor John Waihee has enlisted the help of the University of Hawaii, the private health sector including the hospitals and practicing health professionals, as well as his own State Health Department and key Federal groups such as the Tripler Army Medical Center in a volunteer effort to help address the pressing health problems of those neighbor nations.

Supported by community-wide donations to defray the costs of travel for volunteer health teams from Hawaii, the Health Promotion Center is addressing the problems of otitis media, diabetes, mental health, health infrastructure development, and technical skills training, on site, in the Basin.

This supportive effort guided by political and health officials from the Pacific Islands and served by a Joint Secretariat from the Hawaii State Health Department and University of Hawaii is also designed to reveal health promotional methods and procedures that may be useful in Hawaii.

Without the Federal Pacific Basin support resources made available by this Committee to serve as a nidus for this Federal-State-Community effort, this health outreach in the Pacific--an area so critical to our country--would not be possible. We urge you to continue it! The federal resources currently support a series of projects that are contributing to overall health enhancement in the Basin. They include:

1. A project to develop a unified and practical data system.
2. A special program to increase and improve nurse manpower resources.
3. A project to provide health collaboration between and among the island nations.
4. A training program to develop needed technical skills for health personnel.
5. A project to provide special health services on site in the Marshall Islands.

6. A support program to provide technical backup for medical personnel assigned to duty in the Basin.

On a related issue, Mr. Chairman, this Committee has seen fit, with a special boost from our worthy Senior Senator Daniel K. Inouye, to provide resources for the operation of several Prevention Centers. Three of those centers are currently funded and one center--an international center established at the University of Hawaii's School of Public Health--has been named but not supported with funds.

In the current fiscal year resources have been allocated to fund three National Prevention Centers and one International Prevention Center. The University of Hawaii proposal for an International Prevention Center, which focuses on underserved populations including Hawaiians and the people of the Pacific, will be submitted to the PHS' Centers for Disease Control on June 1st. We are hopeful that the needs of the island communities will be favorably considered and that our grant will be found to have the scientific merit that we believe is amply demonstrated in the content as it is processed through a rigorous peer review process.

We urge you to continue the funding for this valued effort designed to reduce unnecessary medical treatment costs and enhance self-responsibility through health promotional research efforts. Resources are presently available to cover four centers. We urge the committee to expand that to provide resources for up to ten centers throughout our country.

In addition, Mr. Chairman, I would like to summarize the interests of the 24 accredited Schools of Public Health in our nation in having this Committee favorably consider the following legislative recommendations as it pertains to the funding of selected academic health initiatives:

Institutional Support (Capitation)	$5 million
Support for Students (Traineeships)	$5 million
Preventive Medicine Residencies	$3 million
Prevention Centers	$5 million
Special Projects	$5 million
Total	$23 million

Mr. Chairman, I would like to make some brief remarks for my colleague Dr. Jean Lum, Dean of the School of Nursing at our University, regarding their readiness to participate in the National AIDS movement including research efforts. As the nation's largest group of health care providers, nurses are in a position to be in the forefront in providing the necessary care to individuals suffering from AIDS and AIDS-related health problems. The University of Hawaii School of Nursing is mindful of its role in properly preparing its students and faculty in Nursing and Dental Hygiene in being knowledgeable about the controversies surrounding AIDS, its transmission, and the role of health care providers working with AIDS patients and their families. The School of Nursing faculty has incorporated appropriate content in its respective nursing and dental hygiene curricula. Additional resources earmarked for nursing programs related to AIDS prevention, education, research, and training would greatly enhance the University's capacity to deal more effectively with the AIDS crisis. The School of Nursing stands ready to accept their role in this most important effort.

Thank you for this opportunity to provide this testimony, Mr. Chairman.

Senator INOUYE. I thank you very much. I am certain you are aware that I am constantly reminded of the tragedy that is now happening in the United States among native Americans. The cycle of ethnic destruction must be stopped. I have long maintained that the U.S.Government has a special trust responsibility as it relates to native Americans. The statistics you have quoted can be duplicated for native American Indians, and in some cases are worse. Maybe the record should be so indicated.

Among native American Indians, the unemployment in the reservations today exceeds 47 percent. In some of the reservations, the unemployment is as high as 95 percent.

Among the Indians, for those above the age of 50, 55 percent are diabetic. The Indians are now experiencing the highest incidence of suicides among any ethnic group in any age bracket, and this is the same for alcoholism. Poverty is rampant; 22 percent of their homes have no water, electricity, or toilet facilities. Something has to be done.

I have been chairman of this committee now for about 1 year, and I can assure you that we are working overtime.

I may use this occasion to announce that on my July trip to Hawaii I will be spending all of my time working on native Hawaiian problems, so I will be seeing you in Kiokaha and in Wiamea and in Nalakuli and in Wiminalo and places like that, and all of my time in Hawaii during that period will be spent on native Hawaiian problems.

I will ask my staff to work with OHA to come up with a meaningful program for that period.

I realize that the native Hawaiians are not in the same sovereign category as native American Indians, but let me assure you that in the minds of many of us, you are sovereign, sir.

Thank you very much.

Mr. KIALI. Mahalo, Senator.

STATEMENT OF DR. SHARON MIYASHIRO, DEPUTY DIRECTOR, DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS, STATE OF HAWAII

Senator INOUYE. Our next witness is deputy director of the Department of Labor and Industrial Relations of the State of Hawaii, Dr. Sharon Miyashiro.

Dr. MIYASHIRO. Good morning, Mr. Chairman.

I would also like to thank you for your continuing support of our programs and for giving us the opportunity to testify before this committee on the employment-related needs of Hawaii's people and some of the proposals that our department is initiating to meet those needs.

I'd like to summarize some of the initiatives from our written statement submitted to this committee. Hawaii today is facing a twofold dilemma, an increasingly serious labor shortage, and a dynamic growth in the need for highly skilled workers.

The demographics have changed. Because of the drop in the birthrate in the 1960's and onward, fewer and fewer youth are entering the work force, and I might add that the year 2000 challenge that the U.S. Department of Labor has forecast is already being experienced in Hawaii.

Hawaii's job market is rapidly changing. Already, new industries are being developed. In the last session just ended at the State legislature, we saw concentrations on space, energy, telecommunications, and the information industries.

We thus believe that we must take serious and imaginative action to increase the employability of immigrants as well as those groups that have been marginally linked to our work force, the incarcerated, the illiterate, the welfare recipients, and the handicapped. So multiple are the upgrade needs of this diverse group that only an efficient and effective, comprehensive approach will work.

We propose a one-stop, nonbureaucratic community clearinghouse of services. The department plans to install these centers called JobHelp Stores, on each of our four major islands. Broad-based outreach, bilingual services and multiple employment-related services such as employability development, vocational English courses, training, job placement, child care and other worker rights programs that are in our department, will be provided by various of our agencies both within and without our department as well as community-based agencies. And we hope to have a collocated, convenient, noninstitutional setting for these sites.

Dr. Watada will be speaking next and will focus on our special efforts to reach the Samoan community which has had more serious difficulties in obtaining the traditional training services as well as employment.

Out second initiative focuses on automation in the labor supply information system. Our employment service division handles over 130,000 service transactions serving over 80,000 per year. All of this is done manually. In its 1986 survey, the U.S. Department of Labor found that Hawaii was one of the few States, along with New Hampshire, Rhode Island, Virginia, the Virgin Islands, and Puerto

Rico, that did not have online automation. Although Federal funds can be used flexibly in a number of ways, the reality is, Mr. Chairman, that funds have been diminishing for employment services, and that there really is not an option to use these funds for the development of our automation system.

We are thus seeking your support to automate the job matching function. We see it as vital not only to service job seekers and employers, but also in our efforts to create a statewide human service, human resource delivery system for the State.

Looking to the future, we also need to know whether the type of workers needed 5 to 10 years from now will match those individuals being trained today, our future labor supply.

To meet the skill demands of new industries and to enable our education and training institutions to produce the needed skills among our potential workers, we must be able to accurately describe that future raw material. Unfortunately, the methodology for estimating current and future labor supply has not been developed either nationally or among the States. We thus propose to develop such a system, to identify the future pool of workers by skill, potential job placement, and geographic area. We have detailed our plans in the written testimony submitted to you.

To establish the automation and labor supply information system will require assistance in the amount of $1.1 million. Thereafter, we estimate the automation maintenance to be approximately $30,000 per year.

These proposed projects will assist both our economy and our vital human resources, immigrants and the marginally employable people in our State. They will also serve as models for other States and for the Nation.

PREPARED STATEMENT

But most importantly, Mr. Chairman, they will enable us to meet the challenge of providing opportunities for our people as we compete successfully in the global economy.

Thank you.

[The statement follows:]

STATEMENT OF DR. SHARON MIYASHIRO

Introduction

The Hawaii State Department of Labor and Industrial Relations is pleased to have this opportunity to share with you our plans to serve a growing and needy segment of our community -- the recent immigrants and marginally employable. The problem is becoming more acute for us in Hawaii as we expect to experience a modest to zero growth rate in our labor force within the next three to ten years. Estimated new jobs in the State show a total of 95,810 new jobs by 1995. With a projected increase in new jobs and a modest to zero growth rate in our labor force, we will need to look to other potential labor sources. These changes are coming at a time when future developments call for a more skilled workforce -- a spaceport at South Point, an emerging information industry in Hawaii, telecommunications, and international finance are all very real prospects for us. We must thus make every effort to identify and anticipate future labor supply, as well as provide services to the marginally skilled.

Immigrants and the Marginally Employable

An untapped source to fill the labor shortage is the immigrant population as well as resident marginally employable adults. Over the last five years, Hawaii has received approximately 40,338 immigrants with over 85% from the Pacific Basin, 7,200 refugees from Indochina, and an undetermined number of Samoans, Tongans, and other Pacific Islanders. More than 50% of yearly immigrant arrivals are from the Philippines, 18% from Korea, and 9% from China and Taiwan. Approximately 70% reside on Oahu, 10% on Hawaii, 10% on Maui, and 8% on Kauai.

Immigrants are generally motivated to attain economic self-sufficiency, but are faced with monumental barriers to full employment opportunities. Among Asian immigrants, recent arrivals are characterized by occupational and income levels far below what would be expected given their educational levels. Longer residence appears to result in greatly improved income, but not occupational improvement. A large number of foreign trained professionals are employed in jobs which are considerably below their educational levels (doctors working as orderlies, teachers as maids).

Many Pacific Basin immigrants participate in the labor force and are heavily concentrated in service and farming occupations. Their access to full employment opportunities are severely constrained by language and cultural barriers, lack of basic competency and employability skills, and lack of transferrable job skills as in the case of underemployed foreign-trained professionals.

Immigrants and the marginally employable are a diverse group: youth in transition, the prematurely retired, the underemployed, capable welfare clients, some of the homeless, the underassimilated, as well as the traditional residual categories of the disadvantaged and structurally unemployed. Each element must be reached so as to enhance its opportunities to participate in broader social and economic activities, as well as bring about a measure of self-improvement. Effective access means broad-based outreach, effective training materials, public information media, video materials, telecommunications and distance learning systems, graphics arts support, desktop publishing strengths, and commitment and support.

The Jobhelp Store

A central but flexible locus is needed to address the special employability information and placement conditions facing recent refugee and immigrant families. Both youth and adults in this population group have a wide range of English language deficiencies, general educational development and job skill gaps, as well as cultural and social adjustment problems. The combination of cultural and adolescent adjustment presents a special concern as does intergenerational conflict. Basic skills, career information, cultural awareness, transition into the world of work, apprenticeship and other training options, and postsecondary training preparation programs to meet the needs of these groups can be met best through a cost-effective centrally-integrated delivery of the continuum of all these services.

There is a need to improve the labor exchange process by increasing and facilitating the outreach, registration, and servicing of all levels and types of jobseekers and potential jobseekers at a time of current and projected worker shortages. A model "clearinghouse" for employment and training programs in the community is needed. Included in this need is the delivery of employment and training information as well as developing an awareness of worker rights, benefits, and responsibilities.

The Jobhelp Store would be Hawaii's first attempt to co-locate job assistance services for immigrants and the marginally employable. It is to be a "clearinghouse" of services which will test the effectiveness of a central, easily-accessed and coordinated delivery system. Rather than being the sole proprietary of one employment program, it is a consortium of services under one non-institutional roof in a non-bureaucratic setting managed by the Department of Labor and Industrial Relations (DLIR). The JobHelp stores are to be located on each of the four major islands in the state. Each of these counties is experiencing severe labor shortages which are expected to continue until the year 2000. The stores will be staffed by professionals from several program areas within the Department and from outside. Services are focussed on the immigrant and the marginally employable and include public information, outreach, intake, employability development (vocational assessment and training), job placement, and employer assistance. Flexibility of approach and a focus on the marginally employable person allow easy access to a wide variety of services, much like the modern supermarket or shopping mall. In addition, coordination of resources is assured through the Governor's Sub-cabinet Task Force on Human Services and Resources (which includes the Departments of Health, Human Resources, and Education as well as Labor). Such support will facilitate direct referrals for supportive services should they be needed to enable the person to fulfill his or her potential.

Of the projected 8,000 per year immigrants arriving in Hawaii, 20% will receive Jobhelp services in job preparation and placement on Oahu, Maui, Kauai, and the big island of Hawaii. A 60% success rate in job or training placement is expected in the first year, with 5% rate improvements each year thereafter. Core service elements, such as coordination, information, intake, and referral, will reside in an anchored, mall-front location with adequate service and training space. Basic education, job skills training, counseling, selected institutional information and orientation, and related group activities will take place at the mall-front facility, as well as at external locations through purchase of services. Service delivery will be flexible so as to allow for community services within the Jobhelp Store facility. Each Jobhelp store, except for Kauai, will house five (5) professionals and two (2) clerical staff. Because of its small size, Kauai will have two (2) professionals and one clerk. Where possible, existing resources will be used through referrals to standard JTPA, welfare, vocational rehabilitation or other programs as appropriate. Some client skill needs will be delivered on-site while more extensive ones will be provided on a referral basis with attentive follow up. On-site skills training activities will include job serach and retention, immigration requirements, job-related English, orientation to the world of work, worker rights, pre-apprenticeship preparation, orientation to public transportation, child care skills, transition from school, home, or immigrant status to work skills, and personal finance skills. Due to the non-traditional nature of the client population served, an exploration of assessment software for immigrant needs will be made to discover effective means of computer use in information and assessment processing. Staff will coordinate employer contacts and job referrals, on-the-job training, career shadowing, work experience, job placement follow up, and assist The Jobhelp Store Media center develop appropriate promotional material, direct mail, and contact with employer groups, labor, and community organizations.

Through purchase of services, advisory committee membership, structured referral agreements, and information sharing, strong linkages with other human resource programs is a key operating element of this program. Special focus will be put on linkages with existing immigrant service agencies. The Jobhelp Store bilingual and basic skills training services will be delivered through purchase of service agreements with existing community resources to encourage partnerships with community-based organizations. The Jobhelp Store will have a local advisory sub-committee as part of the overall Jobhelp Advisory Council. Broad government service and community-based representation will be included on these committees. The management coordinator of the program will develop appropriate agreements with service providers for referral and informational purposes.

To adequately implement and test this innovative model for Hawaii's recent immigrants and marginally employable, the Department requests funding assistance for a three-period to operate the four Jobhelp Stores at approxiamately $1,475,000 per year.

Labor Supply

Something exciting is happening in the American economy today -- jobs continue to grow in most industries while, at the same time, the number of young people available to apply for these jobs is declining. Looking to the future, how can we be sure there will be a match between the kinds of workers needed 5 or 10 years from now and the number of workers available with the skills needed? A primary goal of human resource policy is to avert imbalances between supply and demand for workers with specific skills. The decline in workforce entrants and the increased importance of mainstreaming recent immigrants and the marginally employable requires more information and more accurate projections of the future labor force makeup than we now have. Are workers going to be available for Hawaii's new space industries and spaceport, for geothermal energy and a high-energy underwater cable, or for telecommunications and the information industries? Although much effort has been expended in estimating and analyzing future job demand, the nature of future labor force supply has received less attention and is still in a primitive stage of development. In fact, a method for estimating true current and future labor supply has not been developed at either the national or state levels. Not only Hawaii, but other states and the nation as a whole would benefit from such a development. Hawaii is in an excellent position to move forward in this area. Not only is the size of our state manageable for such an effort but the cooperative nature of state, federal and county agencies as well as our relatively simplified structure of government would greatly facilitate action in this area.

The Labor Supply Information System

A Labor Supply Information System is needed to tell us about the future availability of workers and their skills. The system proposed will identify the future pool of workers by skill, by potential job placement, and by geographic area. The data base will include demographic and socio-economic data which will help employment and training program planners, policy-makers, and employers decide about future training needs. The planning and delivery of education, training, counseling and work transition services must have an evaluative tool of their effectiveness. To date, there exists no measure which indicates a future linkage between a program which develops skills and the actual job placement of the completer of that program.

Techniniques to be used include:

1) a computer-based matching system which will track some training program completers to a job placement by searching unemployment insurance (UI) records for matches with training program records;

2) A survey of program completers will be used where matches are unsuccessful;

3) A method for projecting labor supply will use cohort analysis of demographic growth (current patterns will be applied to future population groups but adjusted for shifting trends of employment participation rates);

4) data from educational institutions, training programs, employment agencies, major employers, Unemployment Insurance Division records, and other sources of worker information will be aggregated by skill, potential placement and geographic area.

A method of gathering information on the placement of education and training program completers will be established, aided by the computer match system and follow-up survey of completers. The design will include working with the Department's Unemployment Insurance Division regarding access to the Employment Status Report and the use of a questionnaire of completers not in the report. Schools and training institutions will also have to cooperate in accessing completer social security numbers for confidential use in the matching process. Next will be the planning, designing, testing and implementing of the computerized matching system. The initial design, as well as the final results, will be shared with the U.S. Department of Labor, the Interstate Conference of Employment Security Agencies (ICESA), and the National Occupational Information Coordinating Committee (NOICC) for their review and comment. This review should assure the transferability of the product to other states.

The system will be used in planning employment and training programs such as identifying future program offering needs as well as the evaluation of existing programs. Another outcome will be the designing of a program to serve the needs of a specific group of people. These "target groups" include dislocated workers laid off as the result of a plant/firm closing, persons who have been unemployed for an extended period, displaced homemakers who need to enter the labor force, hard-to-employ high school dropouts, and immigrants. These groups have special characteristics and needs that should be considered in developing an effective program for them.

The system will be capable of identifying future occupational surplus and shortage occupations which, when combined with other features of the system such as demographic and socio-economic information, will allow program planners to identify the employment and training needs of jobseekers as well as employers. It will, for example, provide data on the educational level and the skills of the population in a particular geographic area in the state.

Also benefiting from the supply system will be employers, job developers, and planners of developing and re-developing communities such as West Beach on the island of Oahu and West Hawaii on the island of Hawaii. With current supply information by area, new employers will be able to better locate their businesses and developers will know if an adequate labor supply will exist to staff their projects.

We will need $450,000 to complete the development and implementation of the Labor Supply Information System over a two year period.

Senator **Inouye**. Thank you very much.

When will your JobHelp Store become operational?

Dr. **Miyashiro**. We are looking at fiscal year 1989. If we can get funding for it, we would like to try to put it together even sooner than that, if possible.

Senator **Inouye**. How many immigrants will benefit from this endeavor?

Dr. **Miyashiro**. We are seeing about 8,000 immigrants per year. We are looking to serving 5 or 10 percent, at least 400 people.

Senator **Inouye**. Well, I think the record should note that of all the States in our Union, the State of Hawaii has the highest proportion of immigrants, primarily caused by refugees from Southeast Asia, and I think that the U.S. Government should take note of that and assume some responsibility. The burden of offering refuge and homes for these immigrants has not been equally spread throughout the 50 States, and Hawaii, being one of the most hospitable in personality and in climate, has served as a magnet for many of these people.

But as you have noted, it is an expensive thing. I can assure you that I will do my best to provide the necessary funds to carry out the program that you have cited.

Dr. **Miyashiro**. Thank you very much.

Senator **Inouye**. I thank you very much.

STATEMENT OF DR. ROBERT WATADA, ADMINISTRATOR, OFFICE OF EMPLOYMENT AND TRAINING ADMINISTRATION, HAWAII STATE DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

ACCOMPANIED BY KILALI ALAILIMA, SAMOAN SERVICE PROVIDERS ASSOCIATION

Senator **Inouye**. Our next witness is the administrator of the Office of Employment and Training Administration of the Department of Labor and Industrial Relations of the State of Hawaii, Dr. Robert Watada.

Dr. **Watada**. Good morning, Senator Inouye and members of the committee.

Senator **Inouye**. Good morning, sir.

Would you care to introduce the lovely young lady sitting next to you?

Dr. **Watada**. I certainly would like to. Her name is Kilali Alailima, and she is a staff member of the Office of Employment and Training Administration, and she is also an unpaid staff volunteer for the Samoan Service Providers Association, also known as SSPA.

Senator **Inouye**. Welcome.

I thought she was a teenager, and I learned otherwise.

Dr. **Watada**. She is a very capable staff member.

In the interests of time, please allow me to depart from our written statement and briefly summarize our remarks before your committee.

First of all, on behalf of the State of Hawaii and the Samoan community, we wish to express our deep appreciation for the current year appropriation provided to Samoans living in the United States. Our department, in concert with the Samoan Service Providers Association, has initiated plans to begin operations and programs as soon as the funds become available. We are also ready to assist Samoans living in other parts of the United States, working through established organizations in California and elsewhere.

The State of Hawaii will be responsible for the administration of the funds, and our director feels strongly that the Samoans as a community can develop more readily if they run their own show, so to speak, and operate the program. For this purpose, we have asked Ms. Alailima to be here with us to answer any questions you may have.

Furthermore, a Samoan community-based organization staffed by Samoans will be in a unique position to communicate with other Samoans and better understand their cultural viewpoint. We do not feel that a State agency can run the programs with the same effectiveness as a community-based organization of Samoans.

We recognize that this approach will be slow in yielding results, since even basic professional staff will have to be trained, and we intend to take on this responsibility. However, in terms of an investment in our community, the benefits will be forthcoming, and they will be much sounder.

In our written statement we have chronicled the social and economic status of Samoans in Hawaii. And we would also like to share with you a report prepared by Dr. Robert Franco entitled "Samoans in Hawaii, a Demographic Profile."

I do not wish to belabor the issue with details of the plight of Samoans in our community. We would, however, like to thank this committee and the U.S. Senate for favorably advancing what we are sure is a very important investment in our community. We strongly request continued funding for Samoans living in the United States for fiscal year 1989. This amount would allow us to continue the development of the community-based job training program.

PREPARED STATEMENT

Again, we wish to commend your sincere efforts to assist the Samoan population living in the United States.

Thank you very much.

[The statement follows:]

STATEMENT OF DR. ROBERT WATADA

Introduction

Senator Inouye and Members of the Senate Subcommittee on Labor, Health and Human Services, Education and Related Agencies Appropriations. Thank you for the opportunity to testify today. I am Robert Watada, Administrator of the Office of Employment and Training Administration of the Hawaii State Department of Labor and Industrial Relations (DLIR). Today, I speak on behalf of two organizations collaborating on employment and training programs for American Samoans in Hawaii. They are the Hawaii State Department of Labor and Industrial Relations, which I represent, and the Samoan Service Providers Association (SSPA), a non-profit Samoan community-based organization that has advocated for the needs of Hawaii Samoans and managed employment and training programs for youth. With me is Kilali Alailima, Director of SSPA. Both the State of Hawaii and SSPA have a strong commitment to addressing the problems confronting Samoans in Hawaii.

Description of the Problems

Living in Hawaii conjures up images of a life of casualness and leisure -- sunbathing, surfing, and drinking maitais on shady lanais fronting Waikiki Beach. For the millions of tourists that visit the islands annually, the image fits reality; Hawaii is truly a paradise on earth. Yet, not more than a few miles away from the Waikiki resorts, there exists a world that is in sharp contrast. These are the catchment areas for Hawaii's poor and homeless, not unlike the inner city ghettos found in Los Angeles and other mainland cities. In these areas, the rates of juvenile delinquency, crime, drug use, suicide, teenage pregnancies, and child and spouse abuse are high as are illiteracy, unemployment, and high-school dropout. Names and places, such as Kam IV housing and Kuhio Park Terrace, are well known here. People and instances, such as the following, are commonplace:

-- Tala Lelei, from the public housing area, has been in prison for seven years. With the support of many friends and volunteers, Tala had requested parole and had been turned down three times for reasons unclear to Tala. It may be because he does not have employable skills.

-- Eni Motu is a thirteen-year-old gang leader at a public housing project. He has been arrested twice in the last year for shoplifting, burglary, and possession of firearms. His parents are at a loss. Spanking, threats and pleas do not seem to work. Furthermore, if nothing is done to curb Eni's gang activities, the housing management is threatening to evict the entire family.

-- Fifteen Samoan families living in a slum dwelling in Kalihi are being forced to relocate by the landlord who wants to build a condominium. One family has eleven members living in two tiny rooms. Public housing has a waiting list of 3,000 families. Available rentals are limited and too expensive for most families.

Well over one-third of the population of American Samoans living in Hawaii not only live in these areas, but have no real hope of being free of the clutches of poverty. Nearly half of the population of Samoans in Hawaii is below 17 years of age. Unless measures are taken now to intervene, the likelihood is high that succeeding generations will continue to perpetuate the poverty cycle.

For those of us who work with Samoans, the trends are disturbing. Samoans represent two percent of the all Hawaii population and yet are six percent of the total male incarcerated population and twelve percent of the total youth incarcerated population. The percentage of Hawaii Samoan females who had completed high school (44.3 percent) was 28 percentage points below that of all Hawaii females (72.5 percent). For Hawaii Samoan males, the figures are not much better. Hawaii Samoan males scored 17 points lower (58.4 percent) than all Hawaii males (75.2 percent).

When it comes to jobs, nearly 60 percent of all Samoan males in 1980 were in blue-collar transport, operator, laborer, and service occupations compared to just over 30 percent of all Hawaii males. The majority of Samoan working women were in service and sales occupations. The data suggests that Samoan females were encountering more employment problems than Hawaii Samoan males. The unemployment rate for Samoans in 1980 was nearly twice (10.2 percent) the all Hawaii rate of 4.7 percent. Roughly one Hawaii Samoan family in three was receiving public assistance income compared with one family in ten for all Hawaii. Half of all Hawaii Samoan families were making less than $10,662 a year. In 1980,Samoan households on the average contained twice as many persons (5.0 persons) than all Hawaii households (2.7 persons). They were also more than likely to contain children under 18 years of age. Furthermore, about one family in four was without a male head of the family.

We have often been asked why it has been difficult for Samoans to adjust to the American way of life compared to some Asian immigrant groups. Like most immigrants, Samoans migrate to the United States because of the opportunities it holds for them: better education, employment, higher wages, a more promising future for their children. The movement, however, is largely from a rural/subsistence economy to an urban/cash economy. Approximately 96 percent of the Samoans living within the fifty states in 1980 reside in urban areas with the largest concentrations being in Honolulu (33.4 percent); Los Angeles-Long Beach (19.4 percent); and San Francisco-Oakland (10.4 percent). Furthermore, Honolulu represents the first major urban experience for Samoans, so that their adaptive problems are often more severe than those of other immigrant groups, such as Koreans and Filipinos who can experience urban life before they leave their home countries.

Cultural forces can also have an influence on the adjustment of Samoans in Hawaii. Samoan culture is highly resilient and Samoan conservatism is well noted by anthropologists. The culture is rooted in a hierarchical system of chiefs, known as the matai system. Matais (chiefs) are the decisionmakers for their families and community and are the conduit for the gathering and distribution of resources. Their role in Hawaii, however, is more diluted than it is in Samoa. It is the ministers that, perhaps, play a more crucial role for Samoans in providing a gathering place for Samoan religious and social events. A large majority of Samoans gain a tremendous sense of self-worth in their service to the minister and the Church.

Although the matai and minister are the repositories of culture, they can also be an inhibiting force in facilitating social integration into the Hawaii mainstream. It is a dilemma all Samoans face. To what extent do Samoans participate in the fa'aSamoa (Samoan way of life) and commit their resources to fulfilling social/cultural/church obligations? To what extent do they assimilate and adopt Western values which would have them save in order that they may purchase a home or put a child through college? These are not easy questions and are as difficult as the loss of being separated from one's family and culture.

Response from the Community

Hawaii agencies providing services to Samoans have been well aware of the problems faced by Samoans in Hawaii and the difficulties in serving this population. To address these issues, agencies that included the Catholic Charities, Susannah Wesley, Interagency Council, Kalihi-Palama Immigrant Service Center and others sponsored a 1984 Samoan conference attended by many members of the Samoan community. Conference participants decided that, if progress was to be made, it must come from Samoans themselves and that a Samoan community-based organization was the best approach. This was the beginnings of SSPA.

The Philosophy

The underlying goal of the organization has been to assist our Samoan community in becoming more self-sufficient and self-reliant. SSPA subscribes to the philosophy open minds/open hearts/open doors. For the Samoan community to know they have choices, they first need to know what is available to them. The dissemination of information into the community in ways that our people can readily accept is an important feature of our SSPA's program. Secondly, people need an opportunity to process information -- a form of soul-searching that can be shared with others also experiencing the same difficulties. It enables people to weigh the consequences of maintaining old patterns or adopting new ones. It helps them find new solutions to old problems.

Thirdly, our people need to find employment that adequately provides for themselves and lessons their dependence on welfare. There are a number of obstacles that makes the employability of Samoans difficult. Samoans need training in skills. Many lack the financial resources needed to pay for training to acquire skills. Even more serious is the lack of basic remedial skills to even be qualified for vocational and academic programs. A significant percentage of Samoans lack competency in the English language.

The Proposed Plan

The program being proposed will develop a job training and job placement program tailored to the needs of Samoans statewide. It will differ from existing job training programs because it will be doing extensive outreach through bilingual workers. Information will also be disseminated through Samoan radio, T.V., and through a news bulletin. Linkages will also be made for referrals to service providing agencies coupled with a system for monitoring and follow-up. Special programs will be developed geared to the needs of targeted populations. The targeted groups will include Samoan youth, single parents dependent on welfare, the elderly, and the incarcerated Samoans.

Finally, the program will also be promoting community development to create a climate of self-help and self-sufficiency among Samoans as well as to improve relations and networking with the wider community. A concerted effort needs to be made to overcome prejudices and the negative stereotyping of Samoans in Hawaii. Part of our efforts will be directed at educating the community about Samoan culture and values, as well as encouraging employers to hire more Samoans.

Program Management

The Hawaii State Department of Labor, in collaboration with the Samoan Service Providers Association, will be the fiscal agent and provide oversight and monitoring of the program. SSPA will be developing and managing program operations. This joint effort combines the strength of both organizations in a way that best insures the effectiveness of the program.

In closing, we ask that you please support funding for Samoans. We are seeking a total of $750,000 for our program for the next fiscal year because we believe that an investment now will prevent problems that will be most costly for us in the future. Fa'afetai tele lava. Thank you.

Senator **Inouye**. Dr. Watada, one of the higher honors that I have been privileged to accept is the title of High Talking Chief of American Samoa, a position that was granted to me by law of that territory, and as a result, I have had keen interest in the activities of American Samoa.

I note, for one thing, the vast difference between Samoans residing in American Samoa and Samoans residing in Hawaii. For example, in American Samoa there is a jail or prison that would accommodate 12 persons. This jail is very seldom filled. In fact, when I was there there were two inmates, and the rest of the cells were all empty. Crime is almost nonexistent there. Teenage pregnancies are rare, drug abuse is almost unknown, the type of violence that one has become accustomed to point to Samoans is almost unknown there, and yet we find in Hawaii this terrible stereotype developing, that Samoans are vicious, that Samoans are involved in crime.

Why? Do you know why?

Dr. **Watada**. I think I best ask Kilali Alailima to answer that question. I think she is much more familiar with the situation than I am.

Could I ask her, please?

Senator **Inouye**. I think the record should note that Ms. Alailima's father is a Cabinet member in American Samoa. She is of Samoan ancestry. As such, she should be an expert.

Ms. Alailima, why are Samoans who are highly disciplined and friendly in Samoa, when suddenly thrust into society in Hawaii, finding themselves developing this strange stereotype?

Ms. **Alailima**. First of all, I would like to begin by thanking you very much for your support for programs for Samoans.

This is a very exciting time for us. We were formed 3 years ago because many agencies that had been serving Samoans were alarmed at the trends that we have just spoken about, and their feeling was the best people to really make the change are the Samoans themselves, within the community, and that's why our organization was formed.

At this time it is a very important moment because we have been doing a lot of work in the community, and now that there is funding available, we will be able to do even more.

To get back to your question, I myself am an immigrant to Hawaii, and although my mother is an American and my father is Samoan, when I came up to Hawaii, and I spoke English, I went into cultural shock. And it took me 10 years really to feel like I was a part of Hawaii. It was a very difficult—it is a very difficult adjustment.

When I think of my people, and Samoans that come up from Samoa who come from rural areas that are basically subsistence, they have had no urban experience so that when they come to Hawaii they really do not know how to live within an urban system and access resources, they feel very very isolated.

So they are at even more of a disadvantage than I am. Many come not speaking English or not speaking English well.

I think the answer has to do particularly with the fact that they come from a rural environment to an urban setting. Second, they come from a whole different cultural system. As you know, being the Foa of Samoa, there is a very strong traditional system that still exists today in Samoa, chief system, and it is very different here in Hawaii.

The same kinds of mechanisms do not work for Samoans in Hawaii and in the United States. They have to learn a totally new way, and it is difficult. We cannot look to our older people to teach us how to adapt to a Western setting. We ourselves are learning how to make those bridges between the Samoan way of life and the American way of life. And what I am trying to do, along with many others that are part of this effort, is to try to make bridges for our people that are totally different from any other culture, and bridges that will work for us.

This is a very innovative and creative time for us, and I hope that answers your question. I do not know if it answers it adequately, but we are embarking on an important effort, and we do appreciate your support and look forward to continuing.

Thank you.

Senator INOUYE. Your answer supported a proposal I have advocated for a long, long time. Most people are not aware, but there are more Samoans living in California and Hawaii than in Samoa itself, and so no matter what is said or done, Samoans want to live elsewhere, apparently.

So I have advocated to the government in American Samoa to establish some sort of program to prepare Samoans before they leave Samoa.

Do you think a program like that would make sense?

Ms. ALAILIMA. I would highly support that kind of program. I think there is a lot that can be done that way. There is a lot that can be done when Samoans arrive in Hawaii. We could, I hope through the funds that will be made available, provide assistance to Samoans the moment that they arrive so that they are part of a system that can help them adjust over a period of time.

This kind of work has not really been done, and it needs to be done. I would support that.

Senator INOUYE. Would Samoans qualify to be beneficiaries on the JobHelp Store, which is established for immigrants?

Dr. WATADA. Yes; they would be. The JobHelp Store, sir, would be one of the agencies that could help them.

Senator INOUYE. They would qualify as immigrants.

Dr. WATADA. That is correct.

Senator INOUYE. Well, this is an area that cries out for solutions, and if something isn't done, we will have within our society a very explosive situation. I can assure you that being cognizant of that, we will do our very best.

Dr. WATADA. Senator, we heard that you will be in Hawaii in July to visit some of the areas. We would also like to invite you to look at Kam IV Housing, Kalii Paloma Center, the Kuhio Park Terrace Area. These are the public housing areas of Hawaii, and they are predominantly resided by Samoans.

Senator INOUYE. If I can suggest, if you can get together with one of my staff assistants, Ms. Lurleen McGregor, she is now in the process of setting up my schedule for that July visit. I would like to work that in.

Dr. WATADA. OK, I would certainly like to do that.

Senator INOUYE. Thank you very much, Doctor.

Ms. ALAILIMA. Thank you very much.

Senator INOUYE. Thank you, Ms. Alailima.

STATEMENT OF JEANETTE C. TAKAMURA, PH.D., DIRECTOR, EXECUTIVE OFFICE ON AGING, OFFICE OF THE GOVERNOR OF THE STATE OF HAWAII

Senator INOUYE. Our final witness from the State of Hawaii is the director of the Executive Office on Aging, Dr. Jeanette C. Takamura.

Dr. Takamura, it is good to see you again.

Dr. TAKAMURA. Good to see you, Senator.

Good morning, Senator Inouye. Thank you for permitting me to testify before your subcommittee to comment on the title VI Older Americans Act provisions.

The State of Hawaii is pleased that the reauthorized Older Americans Act recognizes the special needs of our kapuna, our native Hawaiian elders. While the general longevity rates of Hawaii's population are exemplary, the longevity of the native Hawaiian population has consistently fallen below State and national averages. As noted earlier, the life span of our native Hawaiian population falls 10 years short of other ethnic groups in Hawaii.

Today, native Hawaiians and part Hawaiians have the highest death rates in the State in almost every causal category, from cancer to automobile collisions. Mr. Chairman, I know you are familiar with all of the compelling information which reveals the need for Federal initiatives which address the special needs of our native Hawaiian elders. The unfortunate truth is that the native Hawaiian elderly population is more likely to have diseases such as diabetes, high blood pressure, heart trouble, stroke, and arthritis, and to suffer from problems related to walking such as leg disabilities, to be sick and confined to bed at home or hospitalized, and to require prosthetic and other devices.

Senator Inouye, in its 1983 assessment, the Executive Office on Aging discovered that the States' elderly Hawaiians and part-Hawaiians have the highest mental health and activity-of-daily-living impairments among all of Hawaii's ethnic groups. In addition, elderly Hawaiians and part-Hawaiians fall in the highest third of those groups with social resource, physical resource, and economic resource related difficulties, and I know that you are also familiar with all of the various compilations of those difficulties.

Mr. Chairman, the longevity and health of our native Hawaiian population are not the only issues with which the Executive Office on Aging has been concerned. We are deeply saddened by the thought that suicide and aging are realities for a segment of this once proud and vigorous group.

Despite the consistent efforts of a variety of service programs and agencies to reach native Hawaiian elders, participation by kapuna has been far less than that of elders representing Hawaii's other diverse ethnic groups.

The Executive Office on Aging, Office of the Governor, and Hawaii's native Hawaiian organizations view the new provisions within title VI of the Older Americans Act as an important avenue through which older adult benefits and services can be provided in a manner which preserves and restores their dignity, self-respect, and cultural identities.

New funding levels for title VI will mean that our Nation will honor the right of the elders of the native American Indian and the native Hawaiian communities to age with dignity. New funding levels will provide the native Hawaiian community itself with the opportunity to shape effective access and service mechanisms, mechanisms that have eluded professionals, not just in aging, but in other areas including health, social services, housing, and law, and to do this with the full partnership of the aging network.

We urgently request your committee's favorable action on behalf of our native Hawaiian elders.

PREPARED STATEMENT

I would like to thank you again for permitting me to appear before the Senate subcommittee, and I would especially like to thank you, Senator Inouye, for all of your efforts on behalf of the aging network and our native Hawaiian elders. We truly do appreciate them.

[The statement follows:]

STATEMENT OF JEANETTE C. TAKAMURA

Thank you for permitting me to appear before your Subcommittee to comment on several budget items which pertain to our Native Hawaiian elders and to our older Americans in general. I am Jeanette Takamura, Director of the Executive Office on Aging, Office of the Governor, for the State of Hawaii.

The State of Hawaii is pleased that the reauthorized Older Americans Act recognizes the special needs of our kupuna -- our Native Hawaiian elders. While the general longevity rates of Hawaii's population are exemplary, the longevity of the Native Hawaiian population has consistently fallen below State and national averages.

Not unlike the Native American Indian population, the Native Hawaiian population was decimated by disease and social disintegration after the discovery of the islands by Westerners and remains plagued by premature and high mortality rates. Different experts have suggested that the Native Hawaiian population was reduced by 30% or more within 100 years of the discovery of the Hawaiian chain by Captain James Cook.

Today, Native Hawaiians and part-Hawaiians have the highest death rates in the State in almost every causal category -- from cancer to automobile accidents. The Hawaii State Department of Health's Health Surveillance Data reveals that Native Hawaiian men who are 45 to 64 years of age have the highest death rates from high blood pressure and stroke. In comparison to non-Hawaiians, death rates for Native Hawaiian men from high blood pressure are 7.5 versus 1.6 per 100,000. For stroke, the rates are 73.4 versus 42 per 100,000 persons for 45-65 year old men. At the ages of 65 years and older, the rates for high blood pressure and stroke contrast dramatically. They are 117 versus 1130.6 per 100,000 for high blood pressure and 10 versus 393 per 100,000 persons for Native Hawaiians in comparison to non-Hawaiians. The unfortunate truth is that Hawaiian elders are more likely to have diseases such as diabetes, high blood pressure, heart trouble, stroke, and arthritis, and to suffer from problems related to walking (such as leg disabilities), to be sick and confined to bed at home or hospitalized, and to require prosthetic and other devices.

In its A Statewide Needs Assessment of Individuals Age 60 and Over dated 1983, the Executive Office on Aging discovered that the State's elderly Hawaiians and Part-Hawaiians have the highest mental health and activity-of-daily-living impairments among all of Hawaii's ethnic groups. In addition, elderly Hawaiians and Part-Hawaiians fall in the highest third of those groups with social resource, physical health, and economic resource related difficulties. Similar dilemmas have been documented by other ethnic organizations and governmental agencies, including E Ola Mau, a Native Hawaiian health advocacy coalition. Perhaps most perturbing of all is evidence which suggests that suicide rates are highest among our Native Hawaiian men.

The longevity and health of our Native Hawaiian population are not the only issues with which the Executive Office on Aging has been concerned. We are deeply saddened by the thought that suicide and aging are realities for a segment of this once proud and vigorous group. Despite the consistent efforts of a variety of aging, human services, and health agencies and programs to reach elder Native Hawaiians, participation by kupuna has been far less than that of elders representing Hawaii's other diverse ethnocultural groups. Discussions between the Aging Network and Native Hawaiian organizations have led to the conclusion that programs and services to Native Hawaiian elders must be made culturally appropriate. Congregate meals programs, senior citizens centers, and other traditional aging programs and services remain "foreign" to elder Native Hawaiians.

The Executive Office on Aging, Office of the Governor, and Hawaii's Native Hawaiian organizations view the new provisions within Title VI of the Older Americans Act as an avenue through which older adult benefits and services can be provided in a manner which preserves and restores their dignity, self-respect, and cultural identities. The Aging Network in the State of

Hawaii testified in strong support of the Title VI amendments. We believe in the strengths of the Hawaiian culture and in the potential for elderly programs and services to be developed based on its unique elements and processes. Thus, the Aging Network is committed to providing full support to the Native Hawaiian community in its efforts to design and deliver appropriate services to its elders. Toward such an end, the Executive Office on Aging organized a number of initial meetings with groups from the Native Hawaiian community which has led to their continuing dialogue.

New funding levels for Title VI will mean that our nation will honor the right of the elders of the Native American Indian and the Native Hawaiian communities to age with dignity. It will provide the Native Hawaiian community itself the opportunity to shape effective access and service mechanisms -- mechanisms that have eluded professionals not just in aging, but in other areas including health, social services, housing, and law -- and to do this with the full partnership of the Aging Network. We urgently request your favorable action on behalf of our Native Hawaiian elders.

I mentioned at the outset that I appreciate this opportunity to comment on several budget items which pertain to our Native Hawaiian elders as well as to our nation's elderly population as a whole. Mr. Chairman, distinguished members of the Committee, the fact of the matter is that aging is an idea whose time has come. The reauthorization of the Older Americans Act offers American elders and all of us in the Aging Network with a real opportunity to meet some of the challenges presented in those aging related issues which we can only expect will grow in importance and magnitude. I know that you are aware of the fact that unless significant steps are taken now to being to address long term care service system development, quality of care, and financing concerns, these and other issues will quickly become so overwhelming that our nation will be caught in an even more daunting predicament in the not-too-distant future.

The demographics of aging tell us that America is just beginning to experience the ramifications of a Longevity Revolution over which we will never get. The paradigms which shape our daily lives will shift and change as a consequence of it, away from a heavily youth concentration to include a formulation of new roles, spheres for contributions, and programs for our elders. At the same time, we will, of course, see a growth in the diverse needs of our older adults.

Because of the foregoing, the importance of ensuring that the Commissioner of the Administration on Aging has a direct reporting relationship to the Secretary of the Department of Health and Human Services as well as the latitude, if not the mandate, to begin the important collaborative discussions around concerns which cross organizational lines cannot be stated or underscored enough. The aging agenda of the immediate future will require substantive attention to long term care, older adult employment, elderly housing, consumer protection, and other items which already loom large. This means that structural and organizational facilitation is essential as is the commitment of increased funds to the Administration on Aging's programs. If we truly wish to be a nation in stride with, or better yet, a nation ahead of its time, we can scarcely afford to continue to fund aging programs at maintenance levels.

Thank you once again for permitting me to appear before the Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Issues.

Senator INOUYE. I thank you very much, Dr. Takamura.

I think the latest statistics would suggest that we are now spending approximately $1,500 per American for curative medicine, while at the same time we are spending about 50 cents per American for preventive medicine, and this in the face of a report from the Secretary of Health that indicated that much can be done just in 10 categories such as smoking, diet, exercise, et cetera.

Your report would suggest that greater emphasis on prevention would help elder Hawaiians.

Would you agree?

Dr. TAKAMURA. I think this is certainly true.

Senator **Inouye**. I think these numbers should be repeated; 117 versus 1,130 per 100,000 for high blood pressure. The 117 is the number for the United States?

Dr. **Takamura**. No; the 117 refers to the number in Hawaii, so we are looking at the general population as compared to the Native Hawaiian population, and as you——

Senator **Inouye**. Well, the general population in Hawaii, 117 out of 100,000 would have high blood pressure.

Dr. **Takamura**. That is right.

Senator **Inouye**. But among the Hawaiians, 1,130?

Dr. **Takamura**. That is right.

So we are looking at data which I think is very dramatic for a native Hawaiian elder population, and I think that if you look at the compilation of all the data that exists, then certainly we do have a compelling case.

Senator **Inouye**. And this is the type of difference in just about every health category?

Dr. **Takamura**. Yes; that is true.

If we look at the various health categories on which the Executive Office on Aging did its assessment in 1983, as noted in the testimony, we find that our native Hawaiian elders fall very far down in terms of health conditions.

Senator **Inouye**. Do you happen to have with you the statistics on diabetes?

Dr. **Takamura**. I don't have them with me right now, but I certainly could get it for you.

Senator **Inouye**. Would you provide us with your statistics on all of the categories you have listed here on diabetes, cardiac problems, respiratory problems?

Dr. **Takamura**. Yes, certainly.

Senator **Inouye**. If what you have cited is what is existing now, I think the statistics on the others must be equally horrible.

Dr. **Takamura**. Unfortunately, I think that is true, and this is part of the reason why we are, in fact, looking at title VI of the Older Americans Act as reauthorized as a real opportunity to in fact make a difference in our native Hawaiian elderly population.

If we were to really look at our native Hawaiian population, I think the real tragedy is that our native Hawaiians are not permitted to age, and then, if they do, are not permitted to age with dignity.

So truly, this particular provision and the funding of it I think is absolutely critical.

Senator **Inouye**. I became acquainted with an organization of native Hawaiian health providers, Elimao. I hope your agency is working closely with them.

Dr. **Takamura**. Yes, we are.

In fact, title VI and the discussion of the inclusion of our native Hawaiian elderly population has provided us with a renewed opportunity to again engage in many discussions with our native Hawaiian population, and in these discussions, what has emerged again is a commitment to work in full partnership toward meeting some very essential goals on behalf of our elders in Hawaii.

Senator **Inouye**. I thank you very much, Doctor.

Dr. **Takamura**. Thank you very much.

Senator INOUYE. I would like to thank all the witnesses from the State of Hawaii for traveling long distances to be with us, to share your wisdom and your advice. We are most grateful.

STATEMENT OF J. RICHARD MUNRO, MEMBER, BOARD OF DIRECTORS, JUVENILE DIABETES FOUNDATION INTERNATIONAL

Senator INOUYE. And now we will hear from witnesses interested in the National Institute of Diabetes, Digestive and Kidney Diseases.

Our first witness represents the Juvenile Diabetes Foundation, Mr. J. Richard Munro.

Welcome to the committee, sir.

Mr. MUNRO. Thank you, and good morning, Mr. Chairman.

My name is Dick Munro. I am the chief executive officer of Time, Inc., and I am here today in my capacity as a member of the board of directors of the Juvenile Diabetes Foundation [JDF], a voluntary health organization that since 1971 has raised over $45 million for diabetes research.

For the record, I might also note that from 1983 to 1986 I served as a member of the National Diabetes, Digestive and Kidney Disease Advisory Council.

The issue that brings me before this committee is the fiscal year 1989 funding for the National Institutes of Health. I am concerned with this on two levels. First, as a businessman and taxpayer, I believe that with adequate investments in research, the societal costs of diabetes, currently estimated at about $14 billion a year, can be reduced and eventually eliminated.

Second, for the Munro family, diabetes is not a medical abstraction, a disease that touches other people's lives. My wife Carol and I are the parents of two diabetic children, Mack, age 16, and Doug, age 19. My involvement with JDF has left me with the firm conviction that if this country is willing to provide the necessary resources and support, we can add diabetes to the list of diseases that have been conquered by medical science.

I know that your committee shares that conviction, and on behalf of JDF, I would like to thank you for all you have done to make possible the dramatic progress of the past few years.

When JDF was founded several years ago, there was no Federal diabetes research program to speak of. A decade ago, this committee had the courage and the foresight to direct NIH to implement the National Commission on Diabetes Long Range Plan to Combat Diabetes. This was a real turning point. We now have a comprehensive and multifaceted research, prevention, education and control program that has become a model for biomedical research in a whole range of health problems.

You listened, deliberated and then acted, and you acted decisively. And thanks to you, Federal investment in diabetes research is already paying enormous dividends. For example, with Federal research dollars, scientists have made it possible for the majority of diabetic women to have normal pregnancies.

With Federal research dollars millions of diabetics are benefiting from new drugs and new ways of taking insulin.

Because of Federal research dollars, diabetics can now avail themselves of laser therapy to reduce significantly the risks of blindness.

And with Federal research dollars, scientists have initiated clinical trials in which humans are undergoing pancreatic islet cell transplantation. Utilizing the same technology, investigators have actually cured diabetes in animals.

Much, then, has been accomplished yet much remains to be done. Despite all the advances we have made, diabetes remains a leading cause of heart disease, blindness, kidney failure, and neurological disorders. It continues to cripple and to kill thousands of our fellow citizens, and the dream of diabetes remains exactly that, a dream. It is nearer than ever, but still beyond our grasp.

In order to keep that dream alive and to maintain the momentum that we have built up over the last decade, JDF strongly, strongly supports an increase of 8.5 percent above current services for NIH, as recommended by the Ad Hoc Group for Medical Research Funding, comprising over 150 health organizations.

Funding at this level would enable NIH to support 7,400 new and competing grants in 1989. It would permit an increase in the number of research trainees as recommended by the National Academy of Sciences.

With this funding, more of the recommendations made in the National Diabetes Advisory Board's long-range plan could be implemented. One such recommendation is the establishment of interdisciplinary research programs on diabetes. This would mean that for the first time we would be able to bring together in existing laboratories the broad range of diabetes related research and capitalize on exciting new breakthroughs in scientific methodologies.

Senator, I have a pretty good idea of the hard choices you face in framing your budgetary choices. It is never an easy process, and given the reality of the Federal deficit, it is an extraordinarily difficult one. And yet, I believe it would be a tragic mistake to halt the amazing advances that we have made against diabetes.

PREPARED STATEMENT

In the final analysis, the investments we make now in finding an answer to the destructive riddle of diabetes will mean immeasurable long-term reductions in the resources consumed treating this disease, and there will also be immeasurable benefits, the suffering that will be stopped, the pain that will be prevented, the hope that will be instilled.

Please help make all this possible. Please give the NIH the funding that it needs.

I thank you very much.

[The statement follows:]

STATEMENT OF J. RICHARD MUNRO

Summary of Recommendations:

The Juvenile Diabetes Foundation International recommends that, for FY 1989, the National Institutes of Health be appropriated $8.2 billion (a 23% increase over the FY 1988 funding level). The National Institute of Diabetes, Digestive and Kidney Diseases (NIDDK) should be appropriated $680.5 million; the National Heart, Lung, and Blood Institute (NHLBI) - $1,188 million; the National Eye Institute (NEI) - $277 million; the National Institute of Child Health and Human Development (NICHD) - $488 million; the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) - $658 million; the National Institute of Allergy and Infectious Diseases (NIAID) - $886 million; National Institute on Aging (NIA) - $240 million; National Institute of Dental Research (NIDR) - $155 million; National Cancer Institute (NCI) - $1,807 million; National Institute of General Medical Science (NIGMS) - $799 million; and the Division of Research Resources (DRR) - $453 million.

We also recommend that $14 million be appropriated for the Centers for Disease Control's State Diabetes Control Projects.

The Juvenile Diabetes Foundation International (JDF) appreciates this opportunity to present its views regarding FY 1989 appropriations for the National Institutes of Health and other federal diabetes programs. JDF is an international voluntary health organization of over 160 chapters and affiliates throughout the U.S. and the world dedicated to furthering research in diabetes and improving the quality of life of the diabetic.

A DECADE OF REMARKABLE PROGRESS.

Thirteen years ago, the federal government embarked in earnest to implement the National Diabetes Advisory Board's (NDAB) Long Range Plan to Combat Diabetes. In 1975, there was no federal diabetes initiative to speak of -- little funding and no infrastructure. The biomedical research community's commitment to diabetes research could be characterized as benign neglect of a disease which wreaked havoc upon virtually every body system -- the eyes, the heart, the kidney, the nervous system -- draining the spirit and resources of young families facing life with a child with an incurable chronic disease and sapping the economy of billions of dollars in health care and lost productivity.

The Federal Diabetes Program.

Several of you who served on the Appropriations Committee at that time heard our message. This Committee and the Congress created the National Commission on Diabetes, which, in 1975, issued the Long Range Plan to Combat Diabetes (Long Range Plan). This Plan provided a blueprint for a major research onslaught on diabetes. The Congress directed NIH to create a multi-faceted research, prevention, education, and control program that has come into its own, a model for biomedical research and many times emulated to attack other major health problems.

AT THE CROSSROADS: A CRISIS YET UNRESOLVED.

As discussed above, Congress' willingness to invest in the Long Range Plan has yielded remarkable dividends in terms of ameliorating the human suffering from the scourge of diabetes and providing the potential for a cure. Despite the cause for optimism in diabetes research, the specter of diabetes and its devastating complications is pervasive. In the United States:

*Diabetes is the third leading cause of death by disease.

*Diabetes is the leading cause of new cases of adult blindness.

*Diabetes accounts for 30 percent of new cases of end stage renal disease (ESRD), and is projected to account for 50 percent of these cases by the year 2000.

*Diabetes is the cause of over 40,000 amputations costing an estimated $302 million each year, which does not include rehabilitation or disability costs.

*Heart disease is twice as common and more often fatal in diabetics than in the general population.

*Diabetic women's babies have a three-fold increase in frequency of birth defects, a five-fold increase in other complications that require early intensive medical care, and a higher mortality rate than babies born to non-diabetic women.

The revised Long Range Plan also expounds a tale of a disease with staggering economic dimensions. A conservative estimate of the total annual direct costs attributable to diabetes is $14 billion. The annual hospital costs for amputations related to diabetes exceed $302 million. The annual Medicare costs for diabetes-related kidney disease is more than $450 million, a number which is expected to double in the next decade as diabetics will account for more than one-half of all ESRD patients. To illustrate the necessity to invest in finding a cure, we need to realize that, the federal government currently spends twice as much to dialyze diabetics as it does to cure the underlying cause of end stage renal disease -- diabetes. Moreover, the potential savings involved in translating research advances "from bench to bedside" are even more phenomenal when one considers that diabetics now account for about 30 million hospital days per year.

A TIME FOR RECOMMITMENT: JDF's FY 1989 APPROPRIATIONS RECOMMENDATIONS.

Administration Budget.

While JDF acknowledges that the Administration, in a substantial departure from the past, has proposed a modest increase of 5.8 percent for NIH in FY 1989, we are disturbed that this budget would nonetheless fund at best 200 fewer new and competing research grants and 4 fewer research centers. To put the matter in proper perspective, it will take funding of $7.6 billion, or a 14 percent increase, just to maintain NIH research programs at their current operating level. Thus, the Administration proposal falls well short of what is needed to maintain current research momentum at NIH.

Moreover, our national commitment to medical research has not kept pace with research and development budgets across the government. According to the National Science Foundation, federal funding for research and development at the Department of Defense, measured in 1978 constant dollars, has increased 98 percent over the past 10 years, while spending for health research at NIH and ADAMHA has increased only 17 percent during the same period.

The Ad Hoc Coalition's for Medical Research Recommendations.

The dividends from the federal investment in biomedical research -- a healthier America -- warrant a NIH investment comparable to, and even modestly exceeding, government-wide funding increases for research and development. As we approach a major turning point in biomedical research in general and diabetes research in particular, we must make a determination as to whether we follow the path of retrenchment or the path towards capitalizing on scientific opportunity.

For us, the choice is clear. JDF recommends that Congress appropriate $8.2 billion for NIH in FY 1989, as allocated on the table of recommendations appended to this testimony. Along with over 100 scientific and voluntary health organizations, we recommend that the National Institutes of Health be funded at the levels adopted by the Ad Hoc Group for Medical Research Funding. This request represents a 23 percent increase in the NIH budget for FY 1989.

Under this proposed budget, NIH would fund about 7,400 new and competing research grants. The proposal would also facilitate the funding of 41 percent of approved research grant applications, a further step towards achievement of an award rate of 50 percent by FY 1992. All grants should be awarded at study section-recommended levels and not be subject to downward "negotiation" which embodies the potential to compromise the quality and integrity of NIH-supported research. In addition, the Ad Hoc Group's recommendation would provide sufficient funding to increase the number of research trainees, an area of great concern to JDF. In order to ensure program balance, all mechanisms, including training, centers, cooperative clinical research, and intramural research, should be increased by the same percentage as research project grants.

Diabetes-Specific Initiatives.

Funding for the National Institutes of Health at the levels recommended by the Ad Hoc Group for Medical Research Funding, including our recommendation of $680.5 million for the National Institute of Diabetes and Digestive and Kidney Diseases, would enable NIH to commence implementation of the more significant recommendations of the National Diabetes Advisory Board's Long Range Plan:

Interdisciplinary Research Programs. JDF strongly supports the recommendation of the NDAB that NIDDK establish several Diabetes Interdisciplinary Research

Programs. The new programs would be designed to integrate diabetes-related research and diabetes-oriented scientists, both young and established, into existing basic science laboratories to capitalize on exciting new basic science methodologies and the attendant scientific talents for the benefit of diabetes research.

JDF views this initiative as the most exciting and promising of the NDAB recommendations. New diabetes interdisciplinary research programs would greatly accelerate national efforts to pinpoint the underlying causes of both Type I and Type II diabetes and to develop more effective treatments. Remarkable advances in the basic sciences are expanding scientific discovery in many disease categories. Experts in diabetes now recognize the benefits that basic science disciplines - such as genetics, molecular biology, virology, protein chemistry, receptor signalling, and immunology - could contribute to the accumulation of vital knowledge about diabetes. JDF looks forward with great anticipation to the results from several colloquia being held by NIDDK to explore in greater depth the possibilities for this promising idea.

CENTERS FOR DISEASE CONTROL (CDC).

The cost-effective application of current diabetes treatment information is being demonstrated through CDC programs in 20 states, but these programs have been severely hampered since its inception because of inadequate funds to fully support various intervention projects.

JDF believes that these state diabetes control programs should be adequately funded and that Congress should, pursuant to the NDAB's recommendation, expand support for the Diabetes Translation Center (DTC) at the CDC, which will more rapidly transfer diabetes research into patient care.

CONCLUSION.

Several of the members of this Committee have made history. You helped create the National Commission on Diabetes, whose Long Range Plan became the foundation for the federal diabetes effort. The research which you have funded over the past decade has yielded huge dividends in terms of reduced diabetic mortality and morbidity and reduced health care expenditures.

Ten years from now, will we feel a great sense of reward, because the research advances funded by Congress today have yielded a cure for diabetes? Or will we look back over a long line of opportunities foregone, and a diabetes program atrophying for want of federal support?

JUVENILE DIABETES FOUNDATION: FY 1989 APPROPRIATIONS RECOMMENDATIONS[1]

in millions of $

NATIONAL INSTITUTES OF HEALTH	FY 1988 Approp.	Diabetes Dollars In FY 1988	Admin. FY 1989	JDF Recommendation
National Institute of Diabetes, Digestive and Kidney Diseases	535	146.7	566	680.5
National Heart, Lung and Blood Institute	966	15.4	1,045	1,188
National Eye Institute	225	22.9	234	277
National Institute of Child Health and Human Development	397	13.0	418	488
National Institute of Neurological and Communicative Disorders and Stroke	535	9.4	571	658
National Institute of Allergy and Infectious Diseases	639	6.0	745	886
National Institute on Aging	195	4.1	206	240
National Institute of Dental Research	126	3.6	131	155
National Institute of General Medical Sciences	633	2.5	689	779
National Institute of Environmental Health Sciences	216	.2	223	266
National Institute of Arthritis, Musculoskeletal and Skin Diseases	148		159	182
National Cancer Institute	1,469	1.0	1,593	1,807
Division of Research Resources	368	19.4	358	453
National Library of Medicine	68		71	84
John E. Fogarty International Center	16		16	20
Office of the Director	62	.5	59	76
Buildings and Facilities	48		5.0	59
TOTAL NIH	6,667	245.5	7,123	8,221

[1] Figures in columns may not foot because of rounding.

Centers for Disease Control Diabetes Control Project	7.2	(7.2)		14

Senator **Inouye**. I am certain you are aware that we are presently involved in the budgetary process, so the final numbers have not been arrived at and as you have noted, it is a very difficult process.

But I can assure you that at this moment the activity you are interested in will be one of those wherein an increase funds will be provided, not to the level recommended by the special ad hoc group, but it will be increased.

Mr. **Munro**. We thank you.

Senator **Inouye**. And if we get together with the House in a favorable conference, it could be further increased.

So let me assure you that we have heard your plea, and we will respond to it.

Mr. **Munro**. Thank you very much.

Senator **Inouye**. Thank you.

STATEMENT OF JOHN T. FARRAR, M.D., PRESIDENT, DIGESTIVE DISEASE NATIONAL COALITION AND CHAIRMAN, PUBLIC POLICY AND GOVERNMENT RELATIONS COMMITTEE, AMERICAN GASTROENTEROLOGICAL ASSOCIATION

Senator **Inouye**. We will now call upon the following to constitute a special panel; Dr. Stanley B. Benjamin, representing the American Society for Gastrointestinal Endoscopy; Dr. Paul Berk, representing the American Association for the Study of Liver Diseases; Dr. John T. Farrar, the president of the Digestive Disease National Coalition; and Ms. Laurie Kovins, representing the National Foundation for Ileitis and Colitis.

I am beginning to get a stomach ache just mentioning those things.

Shall I call upon Dr. Benjamin first?

Dr. **Farrar**. I would like to speak first.

I am Dr. Farrar, a physician, and I am chairman of the panel.

Mr. Chairman, I am very pleased to appear before you to discuss Federal funding for digestive disease [DD] research and training. Today I appear before you both as president of the Digestive Disease National Coalition and in my capacity as chairman of the Public Policy Committee, the American Gastroenterological Association.

The Digestive Disease Coalition is comprised of 22 national voluntary and professional organizations, including the American Gastroenterological Association, representing more than 110,000 individual and corresponding members. The purpose of this coalition is to foster the continued development and progress of Federal efforts to combat digestive diseases, not only curative, Mr. Chairman, but also preventative, and related nutritional disorders.

Others on the panel today will discuss specific digestive ailments that confront us, while I will focus on the need for continued development of research and training activities within the NIDDK.

The constituency organizations supporting the NIDDK meet each year to determine a recommended budget for NIDDK based on the professional judgment and projections of the Institute, the needs of the research community. This year we met in February and developed a recommendation for $680.5 million for the NIDDK. This level of funding would allow a stabilization of current activity and provide for modest growth in research grants, centers and training programs.

We support the figure of $8.2 billion for all of the NIH, not including facilities, and $8.5 billion overall.

I understand what you told the previous witness, that it may not be that great, but we do support that coalition figure because we think there are substantive reasons to support the research effort in this country.

I wish to make several brief points in the remaining minute and a half. Investigator initiated research grants are the core of the NIH's supportive research in this country, and these research grants must be adequately funded for the research effort to go forward.

No. 2, the digestive disease research centers have made a great contribution to progress in digestive diseases, and they deserve the support. These centers, research centers, have added an extra dimension to the excellence of the NIDDK in their efforts toward DD.

Three, the shortage of manpower in the field of digestive diseases continues to be a major concern. We stand to lose many of the best of this generation's bright investigators if we do not support training adequately. Research training is crucial to the future of medical research in this country.

PREPARED STATEMENT

Thank you, Mr. Chairman, for all of your support over the past years to DD research. We realize the severe budgetary problems the country has this year, but we ask you to continue to fund our research effort.

I would now turn to others on the panel to continue this testimony.

I would ask Mr. Paul Berk to continue.

[The statement follows:]

STATEMENT OF JOHN T. FARRAR

Mr. Chairman and members of the Subcommittee, I am very pleased to appear before you to discuss federal funding for Digestive Disease Research and Training programs.

Today, I appear as President of the Digestive Disease National Coalition and in my capacity as Chairman of the Public Policy and Government Relations Committees of the American Gastroenterological Association.

The Digestive Disease National Coalition is comprised of 23 national voluntary and professional organizations representing more than 110,000 individual and corresponding members. The purpose of this important coalition is to foster the continued development and progress of federal efforts to combat digestive diseases and related nutritional disorders. Representatives of our panel today will discuss several of the specific debilitating digestive ailments that confront us, while I focus on the need for continued development of research and training activities within the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).

The constituency organizations supporting the NIDDK meet each year to determine a recommended budget for NIDDK, based on the professional judgement and projections of the Institute, and the needs of the research community. This year we met in February and developed a recommendation of $680.5 million for the NIDDK, which represents a 27% increase in funding over the current fiscal year. This level of funding would allow a stabilization of current activity, and provide for modest growth in research grants, centers and training programs. In chart form our recommendations for NIDDK are included at the end of my testimony.

Digestive Diseases exact an enormous toll in terms of disability, suffering, and economic costs. The incidence of chronic digestive ailments account for an estimated 200,000 absences from work each day, resulting in approximate costs of $50 billion each year in lost wages, reduced productivity, health care expenditures and disability payments. Digestive diseases rank tops in the total number of hospital admissions, accounting for $17 billion a year in health care expenditures alone.

The digestive tract begins at the mouth and ends at the rectum. In between are a host of functional organs such as the esophagus, stomach, liver, pancreas, gallbladder, and the small and large intestines. Each of these organs are vital to sustain one's existence. Hundreds of serious illnesses from an occasional stomach ache, to inflammatory bowel disease, various liver diseases, hemorrhoids, ulcers, and cancer of any of these organs can severely disable individuals of any age. Complications resulting from digestive disorders are a leading cause of death in this country.

Research Project Grants

Investigator initiated research grants are a vital component of the NIDDK's approach to digestive disease research. For the record I have included several of the promising investigator initiated research initiatives that are being conducted at NIH, and some of my colleagues on the panel will discuss the various needs and challenges in these areas.

Examples of digestive disease research supported by NIDDK include:

- basic and clinical research into both the normal function of and the diseases of the liver and biliary tract: Areas of basic research include studies on factors initiating and maintaining hepatic regeneration; factors leading to liver cell injury, fibrosis, and death; basic and applied studies on liver transplantation, including techniques of preservation and storage. Areas of clinical research include: cholesterol and pigment gallstones; inborn errors in bile acid metabolism; chronic hepatitis that evolves from autoimmune viral, or alcoholic, disease.

- studies of structure, function, and diseases of the exocrine pancreas: Areas of research interest include hormonal and neural regulation of electrolyte, fluid, and enzyme secretion; receptors for secretagogues; stimulus-secretion coupling mechanisms; gut-islet-acinar interrelations.

- research on the structure of gastrointestinal muscles: the biochemistry of contractile processes and mechanochemical energy conversion relations between metabolism and contractility in smooth muscle, extrinsic control of digestive tract motility, and the fluid mechanics of gastrointestinal flow. Other studies focus on the actions of drugs on gastrointestinal motility, intestinal obstruction, diseases such as irritable bowel syndrome (functional digestive disorders), colonic diverticular disease, swallowing disorders, and gastroesophageal reflux.

- research on intestinal immunity and inflammation; ontogeny and differentiation of gut-associated lymphoid tissue; migratory pathways of intestinal lymphoid cells; humoral antibody response; cell-mediated cytotoxic reactions and the role of cytotoxic effector cells in chronic intestinal inflammation; genetic control of the immune response at mucosal surfaces; parasitic diseases; and diseases such as gluten sensitive enteropathy, inflammatory bowel disease, and gastritis.

Digestive Disease Research Centers

The National Institute of Diabetes and Digestive and Kidney Diseases supports an excellent program in Digestive Disease Research Centers and Nutrition Centers. We are very grateful for your strong support of these centers.

The Centers programs foster an interdisciplinary approach to facilitate collaborative studies among basic and clinical investigators into the causes, diagnosis, prevention, and treatment of digestive diseases and nutritional disorders. Each Center supports a number of scientists whose research expertise is focused on the study of one or more specific areas such as liver disease, inflammatory bowel disorders, motility function, and neuropeptide control of digestive processes. Pilot programs allow young investigators to conduct feasibility studies on new approaches to treatment techniques in an intellectually enriched environment.

At one Center, investigators are studying the mechanisms by which shigella causes diarrhea throughout the world, and investigators have found a binding site for the shigella toxin, and have cloned a gene for this bacteria. This information may lead to the development of a vaccine to control shigella infections.

The Nutrition Centers program are studying the relationship of diet to health and disease; the biomedical and behavioral aspects of obesity and other existing disorders; as well as total parenteral nutrition and combined nutrient-drug interactions and management of patients.

Mr. Chairman, the Digestive Disease Research and Nutrition Research Centers Programs are a very exciting and aggressive approach to the further development of our basic and clinical knowledge of, and ability to impact diseases of the digestive system. A vital area that has yet to be addressed by the Centers concept is that of pediatric GI diseases. We believe that a great deal of expertise could be gained by intensifying our study of digestive ailments in infants and children.

Digestive Disease Training

Mr. Chairman, the shortage of manpower within the field of digestive diseases continues to be a major concern. We stand to lose an entire generation of young, bright investigators if we do not stabilize the NIH training system, and make a research career more attractive. Because digestive diseases are not perceived to be as "glamorous" as some other fields, the problem is compounded. The Institute has provided your Subcommittee with a report that outlines the steps necessary to increase the number of digestive disease investigators. Based on reports made by the National Commission on Digestive Diseases, the National Digestive Diseases Advisory Board, and the Institute of Medicine, the NIDDK is only supporting about one-half of the training grants, post-doctoral fellowships and career awards to adequately meet the research manpower needs in digestive diseases. While the Institute has initiated a plan to enable each NIDDK Division to award a specific number of new research career awards annually, we are not sure that a mere stabilization is adequate. We firmly believe that accelerated efforts must be made to support the development of young investigators into digestive disease research careers.

Finally, Mr. Chairman, allow me to add a few words in support of the digestive disease and liver epidemiology data systems being developed at NIDDK. This valuable information is useful in research and clinical settings. Further, the Digestive Diseases Education and Information Clearinghouse has made significant strides to educate and inform the public and health professionals of the various digestive problems that affect thousands of Americans.

Thank you for all the support you have given to the digestive disease research over the years.

I now turn to my colleagues on the panel to continue this important discussion.

FY 1989 NIDDK PROPOSAL
(dollars in millions)

Mechanism	**FY 1989 Ad Hoc Group Proposal**	**FY 1988 Enacted**	**FY 1989 NIDDK Coalition Proposal**
Research Project Grants			
Competing			
Number	7442	572	752
Amount	$ 1,400.0	$ 97.7	$ 142.2
Noncompeting			
Number	15,382	1,522	1,639
Amount	$ 3,333.2	$ 276.0	$ 343.6
Admin./Supp.			
Amount	$ 18.2	$ 1.4	$ 1.6
Centers			
Number	665	40	50
Amount	$ 721.5	$ 32.4	$ 54.9
Other Research	$ 468.2	$ 16.9	$ 21.3
SUBTOTAL, Research	$ 6,001.0	$ 424.4	$ 563.6
Training			
Number	12,250	917	1,000
Amount	$ 312.5	$ 21.1	$ 25.8
R&D Contracts	$ 623.7	$ 11.9	$ 16.9
Intramural	$ 730.8	$ 60.2	$ 64.8
RM&S	$ 267.0	$ 17.0	$ 19.4
TOTAL	$ 8,237.5	$ 534.6	$ 680.5

Senator INOUYE. Paul?

Dr. Berk, before you proceed, without objection, I would like to include in the record a list of organizations supporting the Ad Hoc Group for Medical Research Funding Proposal for fiscal year 1989. It is a three-page sheet. It begins with Albert and Mary Lasker Foundation and ends with the Whitehead Institute.

[The information follows:]

ORGANIZATIONS SUPPORTING THE AD HOC GROUP FOR MEDICAL RESEARCH FUNDING PROPOSAL FOR FY 1989

November 15, 1988

Albert and Mary Lasker Foundation
Alzheimer Disease and Related Disorders Association
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Optometry
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology--Head & Neck Surgery, Inc.
American Academy of Pediatrics
American Association for Cancer Research
American Association for Dental Research
American Association for Thoracic Surgery
American Association of Anatomists
American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Association of Dental Schools
American Association of Directors of
  Psychiatric Residency Training
American Association of Pathologists
American Association of University Professors
American College of Emergency Physicians
American College of Nuclear Physicians
American College of Physicians
American College of Psychiatrists
American Council on Education
American Diabetes Association
American Federation for Clinical Research
American Foundation for AIDS Research
American Gastroenterological Association
American Heart Association
American Institute of Nutrition
American Liver Foundation
American Lung Association
American Lupus Society
American Narcolepsy Association
American Pediatric Society
American Physiological Society
American Psychiatric Association
American Red Cross
American Rheumatism Association
American Society for Biochemistry and Molecular Biology
American Society for Cell Biology
American Society for Clinical Nutrition
American Society for Clinical Pharmacology and Therapeutics
American Society for Gastrointestinal Endoscopy
American Society for Microbiology
American Society for Pharmacology and Experimental Therapeutics
American Society for Virology
American Society of Clinical Oncology

American Society of Hematology
American Society of Human Genetics
American Thoracic Society
American Urological Association
American Veterinary Medical Association
Americans for Substance Abuse Prevention and Treatment
Ankylosing Spondylosis Association
Arthritis Foundation
Association for Academic Surgery
Association for Surgical Education
Association of Academic Departments of Otolaryngology
Association of Academic Health Centers
Association of American Cancer Institutes
Association of American Medical Colleges
Association of American Universities
Association of American Veterinary Medical Colleges
Association of Anatomy Chairmen
Association of Chairmen of Departments of Physiology
Association of Clinical Research Center Program Directors
Association of Independent Research Institutes
Association of Medical School Departments of Biochemistry
Association of Medical School Microbiology Chairmen
Association of Medical School Pediatric Department Chairmen
Association of Minority Health Professions Schools
Association of Neuroscience Departments and Programs
Association of Orthopaedic Chairmen
Association of Professional Sleep Societies
Association of Professors of Dermatology, Inc.
Association of Professors of Medicine
Association of Program Directors in Internal Medicine
Association of Schools of Public Health
Association of Teachers of Preventive Medicine
Association of University Anesthetists
Association of University Radiologists
Child Neurology Society
Coalition for Health Funding
Conjoint Committee on Diagnostic Radiology
Conjoint Council on Surgical Research
Cooley's Anemia Foundation
Cystic Fibrosis Foundation
Delegation for Basic Biomedical Research
Digestive Disease National Coalition
Dystrophic Epidermolysis Bullosa Research Association of America
Endocrine Society
Epilepsy Foundation of America
ESA, Inc.
Federation of American Societies for Experimental Biology
Foundation for Biomedical Research
Foundation for Ichthyosis and Related Skin Types
Gerontogical Society of America
Health Industry Manufacturers Association
Hospice Association of America
Joint Committee on Health Policy
Joint Council of Allergy and Immunology
Juvenile Diabetes Foundation

Lupus Foundation of America
Medical Library Association, Inc.
National Alopecia Areata Foundation
National Association for Biomedical Research
National Association for Home Care
National Association of Private Psychiatric Hospitals
National Association of State Universities and Land Grant Colleges
National Coalition for Cancer Research
National Congenital Port-Wine Stain Foundation
National Foundation for Ectodermal Dysplasias
National Foundation for Infectious Diseases
National Hemophilia Foundation
National Marfan Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
Orthopaedic Research Society
Paralyzed Veterans of America
Radiological Society of North America
Reflex Sympathletic Dystrophy Syndrome Association
Rehabilitation Institute of Chicago
Society for Investigative Dermatology, Inc.
Society for Neuroscience
Society for Pediatric Research
Society of Academic Anesthesia Chairmen
Society of Chairmen of Academic Radiology Departments
Society of Critical Care Medicine
Society of Nuclear Medicine
Society of Teachers of Emergency Medicine
Society of University Otolaryngologists - Head and Neck Surgeons
Society of University Surgeons
Society of University Urologists
Surgical Infection Society
Whitehead Institute

Dr. **Farrar**. Yes; it is an impressive list.

Senator **Inouye**. I didn't know that there were that many organizations.

Dr. **Farrar**. There are more investigators, however.

Senator **Inouye**. I think my colleagues in the U.S. Senate will be much impressed with this long list because they represent voters, also.

Thank you.

Dr. **Farrar**. Thank you.

STATEMENT OF PAUL D. BERK, M.D., PRESIDENT-ELECT, AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASE

Senator **Inouye**. Please proceed.

Dr. **Berk**. Senator Inouye, ladies and gentlemen, liver disease is a major cause of illness in the United States and one of the principal causes of death around the world. In addition, because of the central role of the liver in so many metabolic processes, studies of basic hepatic biochemistry frequently have had a major impact on our understanding of both liver diseases and diseases elsewhere in the body, and for those reasons, I would urge you to expand your support for both basic and disease oriented liver research as provided for in the budgetary figures that Dr. Farrar has just supported.

Although the payoff from any particular basic research project is unpredictable, major medical breakthroughs have invariably come from basic rather than applied research programs. For example, two decades ago the NIH funded a study of genetic markers in the blood of Australian aborigines and identified a marker that appeared to be largely of academic rather than medical interest. However, that marker proved to be the hepatitis B virus. Among the cascade of important medical consequences of that finding which resulted from an interplay between clinical and laboratory investigation, was the demonstration that hepatitis B is the unrecognized cause of chronic liver disease in literally hundreds of millions of people around the world, particularly in those from Southeast Asia who are now migrating to Hawaii. Proof was found that the hepatitis B virus caused primary cancer of the liver, and a clear understanding of how viruses can cause human cancer in general. Programs and procedures which have virtually eliminated new hepatitis B virus infections in this country except among IV drug abusers have been developed. And the eradication of hepatitis B and the consequent elimination of primary liver cancer worldwide was made an achievable goal, just as the eradication of smallpox was an achievable goal.

These accomplishments have resulted from an investment of well less than $500 million over 20 years, but will save more than 10 or 20 million lives over the next 20 years making this an exceptionally cost-effective program.

Among our next major targets should be cirrhosis which literally means scarring. The cirrhotic liver can result from many types of injury, including viruses, environmental toxins, and alcohol as well as other factors. Basic research is now unraveling the remarkable interplay between the liver cell and its environment and the genetic programs which define how such cells respond to injury. While liver transplantation, in itself a remarkable achievement, can save the lives of patients with advanced cirrhosis, we will spend almost twice as much money this year on approximately 1,100 liver transplants as we will spend on all biomedical research on the liver and its diseases.

How much more cost effective would it be to be able to modify the liver's response to injury and prevent the development of cirrhosis in the first place?

Expanded support for the research programs of NIDDK such as the liver center's program will lead precisely over time to that goal.

PREPARED STATEMENT

Unfortunately, the young clinician scientists essential to such future progress are a vanishing breed in this country. More than two-thirds of the papers published in our premier liver disease journal, Hepatology, now come from abroad, and the principal authors of many of the papers coming from American laboratories are foreign. Although this is not your major focus today, I would urge you at some point to examine the root causes which are driving our best and brightest young physicians out of biomedical research, a field in which America has for so long led the world and which ultimately is essential to our national well-being.

Thank you for your attention.

[The statement follows:]

STATEMENT OF PAUL D. BERK

We come here today to aprise you of some facts regarding disease of the liver, to notify you of the serious nature of such disease, and to urge you to continue and even increase your support for research in this area. As a preamble, we wish to remind you that the liver is one of the few internal organs without which life cannot be sustained for more than a few hours unless replaced by another functioning liver; regrettably, an artificial device will not suffice as it does for many other of the body's organs. Indeed, the liver is the metabolic lifeline of the human organism, responsible for the many complex nutritional, synthetic, detoxification, and biochemical processes that are mandatory for survival. Because of this metabolic centrality, studies of the basic biochemistry and physiology of the liver have frequently had a major and unanticipated positive impact on the understanding and treatment of diseases of diverse origin.

Limited as we are in time and space, we will confine our comments to three topics. First, we will report a phenomenal success story that has evolved with the help of generous research funding, initially from the United States Government and more recently, from private industry; second, we will focus our attention on one of the major disorders of the liver that accounts for untold morbidity and mortality, but about which many important questions remain unanswered; and finally, we will recount our profound concern regarding the status of United States-based research and the potential disaster to American biomedical sciences that threatens should the issue be ignored.

Among the best recognized and most important of the diseases affecting the liver is viral hepatitis. This illness is believed to be of ancient origin, with references to it dating back to Biblical times and to Greek and Roman writings of the fifth century B.C. Over the centuries, the disease has been recognized through the development of jaundice, generally in the context of an epidemic, occurring most commonly in the course of military encounters. After much speculation as to cause, studies undertaken toward the middle of this century suggested that the disease was a consequence of virus infection, two forms of which were believed to exist. That manifesting as "epidemic" hepatitis appeared to be transmitted orally and was referred to as hepatitis A. A second form that became evident at the turn of the century with the introduction of hypodermic needles and, later, with the advent of blood and blood product transfusions, could clearly be transmitted through penetration of the skin. This form became known as hepatitis B. Both viral infections, particularly the latter, were recognized to produce serious illness with prolonged morbidity and not insignificant mortality. Of political consequence was the fact of its devastating effect in the military setting, sufficient at times to compromise the war effort. Nevertheless, research progress of this major disease remained impeded because of the inability to grow the viruses in cell culture or to identify animal models in which to study their characteristics.

The barrier to progress was finally breached two decades ago when an antigen, later proved to be a portion of the hepatitis B virus, was identified in the blood of an Australian aborigine. Dr Baruch Blumberg, a geneticist at the National Institutes of Health, interested in the study of certain features of human serum proteins, mixed a sample of blood obtained from a multitransfused person with hemophilia with a sample from the native Australian and noted a reaction. Through his work and that of others, it soon became apparent that the test system was identifying precipitates of the hepatitis B virus. It must be emphasized that Dr Blumberg was neither a hepatologist nor a virologist and that his experiments were not designed specifically to locate an infectious agent. His discovery can be viewed as scientific serendipity and represents a testimony to nondirected research. For his original and subsequent work, Dr Blumberg received the Nobel Prize for Medicine a little more than a decade later, a remarkable fact in light of the centuries-old knowledge of the disease.

What are the salutary consequences of this discovery? Not only is it now feasible to positively identify a heretofore undefined human virus, but it is also possible to link this agent to acute liver disease; to the development of chronic hepatitis and cirrhosis, problems of immense magnitude in the most populous areas of the world; to a potentially infectious carrier state in the absence of disease in the carrier; and, most importantly, to the occurrence of primary liver cancer, the most common malignancy worldwide because of the endemicity of the virus in these highly populated areas. The recognition of these associations was facilitated by the attraction into the field of scientists of diverse background. Further harvest reaped through their influx, bringing with them their novel and sophisticated research tools, has been the ability to identify additional hepatitis viruses, to enhance the understanding of the mechanism of cancer induction by viruses, and even to accelerate research creativity in regard to other viruses, such as that responsible for the acquired immunodeficiency syndrome (AIDS). Other gains have been the development, through conventional as well as genetic engineering methods, of specific gamma globulins and vaccines capable of preventing spread of the virus, and the recent encouraging efforts to define and test drugs that are useful in the treatment of the viral carrier state. Accordingly, in a matter of two decades, a disease whose biology has remained mysterious for many centuries, and an associated cancer that affects literally millions of persons, now have the potential for eradication if appropriate preventive strategies can be mounted.

A current vital target requiring major attention is cirrhosis. Cirrhosis, a word that literally means "scarring", is not itself a disease but is one extreme form of pathologic response to a number of noxious insults directed at the liver. Best known as a sequel to chronic alcoholism, which indeed is its commonest cause, cirrhosis can be the end result of other injurious events such as viral infection, drug toxicity and chemical damage, metabolic and genetic disorders, immunologic diseases, chronic congestion and biliary obtruction, and nutritional deficiencies. Current evidence is that cirrhosis is the 4th leading cause of death among U.S. males over the age of 40 years, and the 9th leading cause of death for the entire U.S. population. Cirrhosis is an irreversible condition that can have dire consequences including liver failure, the retention of large volumes of body fluids, the induction of gastrointestinal bleeding, and the propensity to promote liver cancer.

There is no specific treatment for cirrhosis. Because of its inexorably progressive course, albeit at varying rates, a now accepted form of management is liver transplantation. As remarkable as this treatment modality has now become, and as effective a form of treatment as it is for some types of cirrhosis, recourse to this costly procedure seems less beneficial for the most prevalent cause of cirrhosis, namely alcoholism.

Indeed, the decision to perform transplantation can be viewed as a sign of therapeutic failure. Would it not be more rational and perhaps cost effective to modulate the livers response to injury and prevent the development of cirrhosis in the first place or to apply a definitive form of therapy capable of reversing the process? Indeed, why some types of injury heal with restoration of normal liver architecture while others progress to cirrhosis, or why, for a given type of injury, some but not all people develop cirrhosis, are critical questions for which answers may at last be on the horizon. Basic studies of cell, molecular and developmental biology are beginning to unravel the interplay between the liver cell and its environment, and the genetic program defining how individual cells and whole livers respond to injury. In no other organ are these types of fundamental studies so advanced, but much more information needs to be gathered before the goal of prevention of cirrhosis or its effective treatment can be achieved.

Finally, achievement of these goals is dependent on the availability of adequate numbers of well trained, committed, young investigators, willing to invest their time and efforts in the pursuit of these critical research objectives. Clearly, they exist, and American medical research continues to play its traditional leadership role. However, we in the AASLD, in the company of investigators from other medical disciplines, discern a downward trend in the pool of U.S.-trained investigators willing to commit themselves to long-term investigative pursuits and are concerned that they may become a vanishing breed. One indicator is the noted decline in the number of articles from U.S researchers accepted for HEPATOLOGY, the scientific journal of our Society. For example, in 1985, 55% of all articles accepted for publication derived from outside the U.S. This figure rose to 59% in 1986, to 63% in 1987, while thus far in 1988, 69% of submitted articles have come from abroad. Furthermore, the principal authors of many of the papers coming from Americal laboratories are foreign-trained physicians or scientists, many of whom are filling otherwise vacant positions in our research training programs. If the current aim to reduce the number of foreign-trained physicians permitted into this country prevails, a serious shortage of effective medical scientists can be anticipated. Although this is not the major focus today, we would urge examination of the root causes, such as the staggering educational debts for U.S. graduates and the insecurity of erratic research funding which are driving our best and brightest out of the research arena in which America has for so long led the world, and which is so essential to our national wellbeing.

Senator INOUYE. On your last point, can you tell us what the root causes are for the drop in interest in biomedical research?

Dr. BERK. I think they are rather complex, but there are at least two issues: one, the enormous debts that most medical students incur in achieving their medical education makes the financial sacrifices of a research career compared to a clinically oriented career rather daunting to many young physicians, and second, the uncertain nature of research funding makes the decision to embark on a research career a very risky one, particularly for someone who has achieved substantial debts. I think some approach to helping those who choose investigative careers with the long-term management of their educational debts, and some approach to a longer term introductory kind of funding for young investigators are at least a part, although not all, of the things that will help alleviate this problem.

Senator INOUYE. Are other countries subsidizing the educational activities of biomedical research students?

Dr. BERK. I think there is no country that erects the kind of financial barriers, no developed country, that we have erected to achieving graduate level education in all of the sciences, but in all fields. In countries like France, for example, students who are qualified to get into their major research oriented institutions are actually paid salaries whereas we are charging enormous tuitions, so that there are various types of subsidies. They vary from country to country, but I think the statement that we have the only system which erects these enormous financial barriers is an accurate one.

Senator INOUYE. Then you are suggesting that the scholarship program at NIH is woefully inadequate?

Dr. BERK. I think all levels of support, scholarships, loans, and others perhaps, need to be reexamined for the impact that the current levels have on our ability to train scientists. I am sure this applies outside the biomedical field as well. We are producing woefully few engineers in many critical categories, and I think again, some of the same problems, although I am not an expert in that field. would apply to all aspects of science and technology.

Senator INOUYE. I should point out that I am interested in your area of expertise because about two decades ago I underwent thoracic surgery, and at that time received some blood. Apparently the blood was contaminated; I ended up with hepatitis. So I know what it is all about.

So you have got one very determined partisan supporter.

Dr. BERK. We will take all the support we can get.

Senator INOUYE. Thank you.

STATEMENT OF LAURIE KOVINS, NATIONAL FOUNDATION FOR ILEITIS AND COLITIS

Dr. FARRAR. Our next witness will be Laurie Kovins of the NFIC.

Ms. KOVINS. Good morning, Mr. Chairman. I am pleased to appear before you to discuss Federal funding for digestive disease research and training programs. Throughout the hearings concerning this funding, I am sure you have heard and will continue to hear a great deal concerning the numbers involved with this program. I would like to put aside the numbers for a moment and address digestive disease, not from the economic, fiscal, or even medical point of view, but from the point of view of the patient, the individual who lives from day to day with chronic disease.

As the daughter of someone who has lived his entire adult life with Crohn's disease, and as one who was also diagnosed with Crohn's disease at the age of 16, after 3 years of being labeled first a late bloomer and then as a victim of anorexia nervosa, I have experienced this disease and how it is misunderstood first hand.

I was diagnosed with Crohn's the summer before my senior year in high school. During the preceding year I had undergone psychotherapy for anorexia nervosa. My inability to eat or gain weight, as well as almost daily bouts of nausea were interpreted as physical manifestations of psychological problems. I would have liked to be able to tell you that after I was properly diagnosed my doctor and I found a program of treatment which would effectively manage the disease but this was not the case.

Over the course of the next 4 years I learned to live with constant nausea, dehydration, fever, abdominal, and rectal cramping. By the end of my sophomore year in college last year, I had developed rectal abscesses and fistula, in addition to the inflammation of my terminal ileum and colon which had been present at the initial diagnosis. My diet, when I was hungry, consisted of strained apricots, saltines, and maybe some Jell-O when I was feeling up to it.

By the end of the semester I was in far too much pain to sit down, attend classes, or even sleep.

When the semester was over, I came home from school and was home for 3 days, during which I couldn't get dressed or stand even to be covered by a sheet because I was in so much pain. I was admitted to Johns Hopkins Hospital in early June thinking that I was there to have an abscess drained. Instead, I had rectal surgery twice in 3 days, was put on TPN, a method by which all nutrition is fed into a major vein rather than orally, and I underwent a major resection of my small bowel, and a colostomy, which is at best an expensive inconvenience, and at worse, a disfiguring, embarrassing alteration of bodily appearance and function.

Since the age of 14 I have been struggling with this illness in one form or another. For 7 years, Crohn's disease has disrupted my schooling, my friendships, and my sense of well-being.

I returned to school this year and have not experienced any symptoms of the Crohn's disease since my surgery. Technically speaking, the disease is in remission. I prefer to think that this remission is permanent, but know that for most people with inflammatory bowel disease, this is not a realistic expectation. The experts say that we are still far from discovering a cure for this digestive disease.

The month of May 1988 has been designated "National Digestive Disease Awareness Month." Although many digestive diseases can be somewhat managed with medical and surgical treatment, digestive disease today is still one of the leading causes of hospitalization and surgery in the United States.

There is a light at the end of the tunnel, however. Some research has led to an inkling of the cause of these diseases, as well as some medical management.

PREPARED STATEMENT

I urge you to support the recommendations of the NIDDK constituency group for the $680.5 million in funding for NIDDK. It represents a 27-percent increase in funding over the current fiscal year, but this would allow for a stabilization of current activities and provide for modest growth in research grants, centers, and training programs, and provide a measure of hope for may individuals with diabetes, digestive, and kidney diseases.

Thank you very much.

[The statement follows:]

STATEMENT OF LAURIE KOVENS

Mr. Chairman and members of the Subcommittee, I am pleased to appear before you to discuss federal funding for the Digestive Disease Research and Training Programs. Throughout the hearings concerning this funding, I am sure you have heard and read pages and pages of testimony concerning the numbers involved with this program; how many individuals are affected by digestive diseases; how much money has been needed and allocated in the past; and how much is needed now.

I would like to put aside the numbers for a moment, and address digestive diseases not from the economic or fiscal point of view, but from the point of view of the patient -- the individual who lives from day to day with chronic disease.

As the daughter of someone who has lived his entire adult life with Crohn's disease, and as one who was also diagnosed with Crohn's disease at the age of 16, after three years of being labeled first as a "late bloomer" and then as a victim of anorexia nervosa, I have experienced this disease and how it is misunderstood first-hand -- from friends, teachers, and even health care professionals.

My father was diagnosed with Crohn's disease when he was about the age I am now - 20 years old. Since that time, he has had surgery a number of times, and has been on medication with side effects such as stomach ulcers, for which he has also been hospitalized. He has lived for twenty years with intermittent pain, loss of appetite, and the stress of never knowing when or in how severe a manner the symptoms of his illness would return.

I was diagnosed with Crohn's disease the summer before my senior year in high school. During the preceding year I had undergone psychotherapy for anorexia nervosa; my inability to eat or gain weight, as well as almost daily bouts of nausea were interpreted as physical manifestations of psychological problems. I spent nine months in psychotherapy on tricyclic antidepressants, being treated for a problem which I did not have. Over the course of that year, my symptoms became worse; I missed school and stopped seeing my friends. I spent most of my time tired, confused, and in pain. When I was finally diagnosed, I found that, like my father, I had Crohn's disease -- a chronic illness for which there is no known cure.

I would have liked to be able to tell you that after I was properly diagnosed, my doctor and I found a program of treatment which would effectively manage the disease, but that was not the case. Because I had been unwell and untreated for so long, and because the onset of inflammatory bowel disease, or IBD, in my case, as it is for many others, is insidious, the prednisone, sulpha drugs, and antibiotics usually administered to IBD patients barely helped control my symptoms. I learned to live with constant nausea, dehydration, abdominal and rectal cramping. By the end of my sophomore year in college, I had developed rectal abscesses and fistulae (unnatural connections between internal body parts) in addition to the inflammation of my terminal ileum and colon, which had been present in the initial diagnosis. My diet consisted of strained apricots, saltines, and maybe some jello, when I was feeling up to it. I was in too much pain to sit down, attend class, or even sleep. I managed to get through the semester only by making weekly visits to my gastroenterologist for rectal dilation. I had developed a daily pattern of spiking a fever of 103 degrees. I would come back from my morning class, crawl under the covers, and shaking, take Tylenol and drink water until the fever broke and the shaking stopped. Sometimes I would go back to my afternoon classes. A lot of the time I just slept.

When the semester was over, I came home from school, and was home for three days, during which I couldn't get dressed or stand to be covered by a sheet, because I was in so much pain. I was admitted to Johns Hopkins Hospital in early June, thinking that I was there to have an abscess drained, have a few tests run, and maybe try some new medication. Instead, I had rectal surgery twice in three days, was put on total parenteral nutrition, a method by which all nutrition is fed into a major vein, and, two weeks after my admission, underwent a resection of my small bowel, and a colostomy -- which is at best, an expensive inconvenience, and at worst, a disfiguring, embarrassing alteration of bodily appearance and function.

Since that time, I have been struggling with this illness in one form or another; for four years Crohn's disease has disrupted my schooling, my friendships, and my sense of well-being.

Please allow me to share with you some brief excerpts from the journal which I kept during my most recent hospitalization.

> Frustrated; resigned; hopeful; angry; desperate; optimistic; tired of being a patient; tired of being a patient. Sick and tired of always being sick and tired. "What a brave, strong, stalwart human being I am in the face of all this difficulty." I'm impressed with how impressed everyone seems to be with me. But I just don't feel anything anymore...I'm in a state of suspended animation; waiting for the surgery; waiting to feel better. Waiting for someone else to address the crisis at hand.
>
> ...36 hours until surgery...I keep running my hand over my stomach. It's ironic that it seems fine from the outside, now, when there is so much disease, but when it looks like a road map, post-op, it will be more whole. I will be more whole.
>
> ....(After the surgery) I've been home for two days. It's great to be home, but...I keep going through these thoughts about the Crohn's. I don't feel much like eating, I have all these weird sensations which I don't understand...I think I am very, very angry somewhere not too deep underneath. Every time anyone has asked how I've been doing, I've smiled and answered "fine." I want so desperately to believe that -- that I'm OK. But I'm not. Not in my mind and not in my body. It galls me to think that I'm going through all of this, and that the effects are, in all likelihood, only temporary. I'm afraid of getting sick again. I think I'm afraid of dying. It's all pretty ridiculous, considering that the surgery I just had is intended to make me well. (But for how long?) What

> happened to my optimism? I didn't think about this during all the years I was sick all the time. Then I knew what to expect -- what I could do. How I would feel.
>
> I can't believe that soon, I'll be able to eat whatever I want, do the things I want to do, be who I want to be, free from pain (if not of the fear of its return). At the back of my mind (now not so far in the back) What if it doesn't work? And even if it does, how long will it last?
>
> I HATE THIS!!!!!

I returned to school this year and have not experienced any symptoms of the Crohn's disease since my surgery. Technically speaking, the disease is in remission. I prefer to think that this remission is permanent, but know that for most people with inflammatory bowel disease, this is not a realistic expectation. I prefer to think that my remission is permanent, to keep a positive outlook, but the experts say that we are still far from discovering a cure for this digestive disease.

My story may appear to have a happy ending, but for myself and the thousands of others who suffer from inflammatory bowel disease, there is no end to the story of their illness. These illnesses are a lifelong experience, a lifelong battle.

There may be a light at the end of the tunnel, though. Researchers have, in recent years found some clues to what may be the cause of Crohn's disease and other related disorders; new drugs have been tested and found helpful in managing the symptoms.

The month of May 1989 has been designated "National Digestive Disease Awareness Month." Although many digestive diseases can be somewhat "managed" with medical and surgical treatment, patients with digestive disorders must also constantly struggle to educate themselves, their families, and the public at large. Digestive disease today is one of the leading causes of hospitalization and surgery in the United States. Yet there is still a great amount of misunderstanding by lay and professional people regarding illnesses such as Crohn's disease and ulcerative colitis.

I urge you to support the recommendations of the NIDDK Constituency Group of $680.5 million in funding for NIDDK, which represents a 27 percent increase in funding over the current fiscal year. This would allow a stabilization of current activity and provide for modest growth in research grants, centers, and training programs.

I will be happy to answer any questions that you may have.

Senator **Inouye**. Thank you very much.

I must confess, this is the first time I have heard of Crohn's disease.

Ms. **Kovins**. Yes.

Senator **Inouye**. How many Americans suffer from Crohn's disease? Do you have any numbers on that?

Dr. **Farrar**. I don't have a number. I'm not sure. I should know the number, but I don't, but the NFIC has 20 or 30 chapters or more around the country. They raise well over $1 million a year in money for research.

It is widespread. I have friends who are in practice in Richmond. Two-thirds of these gastroenterologists patients are Crohn's disease patients. So it is a relatively widespread disease. The actual figures I cannot give you, Senator Inouye.

Senator **Inouye**. And do you have to live with that?

Ms. **Kovins**. Yes; it is a chronic illness. There is no cure right now. The only thing that can be done is medical management.

I have been on several different types of drugs as long as I have had the disease, and until I had very radical surgery last summer, the symptoms never went away, and they could range anywhere from general digestive disturbance, lack of appetite, loss of weight, they can manifest anywhere in the digestive tract, from the esophagus to the rectum.

Dr. **Farrar**. President Eisenhower had this, and it was quite inactive in that form.

Senator **Inouye**. Is that the ileitis?

Dr. **Farrar**. Yes.

Senator **Inouye**. He made that very famous.

Dr. **Farrar**. Not famous enough.

Senator **Inouye**. We are discussing Crohn's disease.

Have you ever heard of Crohn's disease?

Senator **Weicker**. I have heard of it. I am not as familiar with it as I should be.

Senator **Inouye**. I think we are very fortunate to have with us Senator Lowell Weicker. If there is any person who can be called the savior of health, you are looking at him.

Senator **Weicker**. That is a very nice remark.

Senator **Inouye**. Well, you know I mean it.

Senator **Weicker**. I know that the only way you could say it, very frankly, is if you have the support of Democrats like Dan

Inouye, because they have the numbers. I might have the good feelings, but he has got the votes, so you can thank Senator Inouye.

Senator INOUYE. Well, Ms. Kovins, I thank you very much. At least you have introduced me to a new disease. And I will do what I can.

Ms. KOVINS. Thank you very much.

STATEMENT OF STANLEY B. BENJAMIN, M.D., CHIEF OF GASTROENTEROLOGY, GEORGETOWN UNIVERSITY HOSPITAL

Dr. FARRAR. Our last witness, Senator, is Dr. Stanley Benjamin.

Dr. BENJAMIN. Mr. Chairman, Senator Weicker, I am Stanley B. Benjamin, chief of gastroenterology at Georgetown University Hospital in Washington, DC. I appear on behalf of the American Society for Gastrointestinal Endoscopy, an organization representing 3,000 gastroenterologists and surgeons who provide clinical care in conjunction with endoscopic services to a large number of Americans with gastrointestinal diseases.

For purposes of protecting your valuable time, I would request that our testimony be submitted for the record, and that we also support the funding figures that have been previously forwarded by this panel.

With your permission, I would like to, with graphics, demonstrate in a very brief fashion an excellent example of how financial support from the Congress through NIH funding of research is beginning to have a very dramatic effect on a disease that affects many Americans. So I would ask, if I have your permission, to give you a graphic and then tell you a success story.

Senator INOUYE. Thank you.

Dr. BENJAMIN. What I want to talk to you about briefly is colon cancer, which is one of the most common malignancies in this country, with 135,000 to 150,000 new cases diagnosed each year.

As was discussed, preventive medicine is very important with this disease. Of those detected with cancer, at the present time or in the past, only one-fourth are alive at 5 years. So, we are talking about a very large number of people who die.

The past 40 years has been marked by no change in survival rate of these patients, despite dramatic improvements in anaesthesia and other medical services. The question is why, and why do I say there is a very bright future in this?

Through NIH funded research and implementation of those research findings by practitioners in the area of colorectal diseases, there are beginning to be very positive outcomes with this disease. In a variety of NIH sponsored studies, the progression of colon polyps, which are little mushroom like growths on the colon depicted in the top figure on that handout, have been demonstrated to progress to colon cancer. There is additional data that this sequence can be interdicted, and that the removal of these polyps at a precancerous stage dramatically decreases the incidence of that cancer.

For your edification, that top graphic demonstrates a method of removing colon polyps with an instrument such as this rather unwieldy beast which can reach around the entire colon and find these polyps in an outpatient setting, remove them with a snare, and actually prevent their progression to colon cancer.

In addition——

Senator INOUYE. I have reached the stage in my life where I see those things ever so often.

Dr. BENJAMIN. It is not too bad, is it?

The other addition is that cancers can be found at a very, very early stage in their development, as has been demonstrated with President Reagan's bowel cancer which was detected at a very early stage and has been surgically cured.

I would like to say that we have the means, and I think this business of colon polyps and colon cancers demonstrate that using research information, as has been stated by this panel, much of this comes from NIH funded research and a cadre of committed clinicians using equipment such as the colonoscope I have demonstrated, we can improve the health of a large number of Americans.

I think the studies performed and the treatment that is given to people with advanced cancer clearly demonstrates the cost effectiveness of finding diseases before they become very costly and do not result in having people alive at the end of their treatment.

PREPARED STATEMENT

On behalf of the American Society of Gastrointestinal Endoscopy, I would like to thank both of you for your kind attention. I will be glad to answer any questions that you might have.

[The statement follows:]

STATEMENT OF STANLEY B. BENJAMIN

Mr. Chairman and Members, I am Stanley B. Benjamin, Chief of Gastroenterology at Georgetown University, Washington, D.C.

I appear on behalf of the American Society for Gastrointestinal Endoscopy. This organization represents over 5,000 gastroenterologists and surgeons who provide clinical care in conjunction with endoscopic services to a large number of Americans with gastrointestinal diseases.

As in all areas of medicine, research advances coupled with technological improvements are having a positive effect on the overall health of Americans.

For example, nowhere is this more apparent and more promising than in the field of gastrointestinal diseases when colon cancer is considered. This disease is also an excellent example of how the financial support of the Congress, through NIH funding, is beginning to have a dramatic effect on a specific disease.

Colon cancer is one of the most common malignancies in this country; 135,000 to 150,000 new cases are diagnosed each year. This disease affects equally men and women beginning at age 40; it increases in incidence with advancing age. Early detection of the disease is vital to the saving of lives. By the time undetected colon cancer causes problems with normal bowel function, it has usually spread beyond the colon; less than one-fourth of such patients are alive five years after diagnosis.

Despite advances in surgery and chemotherapy with their associated impact on health care costs, there has been no significant improvement in the survival of these patients in the last 40 years.

However, as bleak as this story would seem to appear, the benefits of NIH funded research and implementation of research findings by practitioners in the area of colorectal disease are beginning to alter positively the outcome of this disease.

In a variety of NIH supported studies, the progression of colon polyps to cancer of the colon has been clearly demonstrated. Additionally, there is data demonstrating that this sequence can be interdicted and that the removal of polyps at a precancerous stage dramatically decreases the incidence of cancer. Cancers found in patients without symptoms, such as abnormal bowel function (done as a part of health care surveillance) are often cured by non-surgical endoscopic means resulting in dramatically increased five-year survival rates in these patients. This was clearly demonstrated in President Reagan's bowel cancer which was detected at an early stage before he had any symptoms.

What is stopping us from employing this knowledge and utilizing available techniques in technology to eliminate this disease?

The first is education; educating the American public about this disease and the need for surveillance in the form of occult blood testing and sigmoidoscopy. Educated high-risk patients with polyps and occult bleeding can undergo colonoscopy to remove polyps and find early cancers.

The second is further funding of basic research into the reasons why Americans develop this disease and how to effectively treat those patients with advanced disease--this should be considered as part of an overall plan to lessen the impact of a disease with a high cost in patient suffering and health care outlays. The cost effectiveness of this approach has been demonstrated in large studies and is being confirmed in other on-going clinical trials. These programs require adequate funding through your committee, Mr. Chairman.

The rapid growth of technology and the changing patterns of treatment of diseases often leads to confusion regarding the "best" and most cost effective way of providing medical care. Hard questions need to be directed to the medical profession about costs and benefits, of course.

In the area of colorectal cancer, we have the means of using valuable research information and a cadre of committed clinicians to improve the health of a large number of Americans. The overall costs for early detection of bowel cancer based on the studies performed, compared to the treatment of advanced non-curable disease, are not likely to change; however, through such detection programs we will have a large group of living patients instead of spending our dollars to deliver care that does not prolong survival.

The American Society for Gastrointestinal Endoscopy supports the National Digestive Diseases Coalition request for funding in the several areas, including research training.

We also believe, as the Coalition indicates, that the National Institute of Diabetes and Digestive and Kidney Diseases should receive funding at the level of $680 million for fiscal year 1989.

We also support the Ad Hoc Group for Medical Research Funding figure of $8.2 billion for the NIH, and included in that funding level are necessary funds for construction and research instrumentation.

Mr. Chairman and Members (of the Committee), this single example of early detection of bowel cancer represents the combined efforts of the Congress in providing funds for research, the basic researchers delving into the causes and treatment of disease, and the practitioners quickly translating the research results into improved patient care. Continued efforts by this "team" promises to provide other similar patterns of improvement in the control of gastrointestinal diseases.

Thank you for giving us the opportunity to appear before you and your committee. I will be pleased to answer any questions you may have.

Senator INOUYE. I mentioned with a smile that I have reached the stage in my life where I see those things.

Is it true that a young person need not concern themself with colon cancer?

Dr. BENJAMIN. I think the data clearly demonstrate that the risk begins sometime after the age of 40. There are certain groups that are at risk prior to that, but for the general American population, the risk begins at 40, and it really swings into gear at age 50. At this time, the American Cancer Society and other organizations have recommended surveillance to detect patients at risk and detect the cancer before it becomes a nontreatable disease. The risk progresses linearly, with age, up to a peak incidence at about the age of 70.

Senator INOUYE. Is something like this preventable?

Dr. BENJAMIN. Absolutely. I think the issue of flexible sigmoidoscopy and colon cancer screening, which has come up before the Congress, is really an issue where we decide to spend more than 50 cents, as you pointed out before, on preventive medicine. Does the bill for treatment of a disease, that is not really curable when it is advanced, up the price from $110 to $125, which is really the issue in front of Congress?

Senator WEICKER. Two things.

First of all, Dan is citing his personal experience. I will cite mine because I have also had dealings with this. I think the group that you have got to reach—and I am very serious—are those who have experienced the previous technique. For 10 years I managed to evade the Capitol surgeon on this whole situation because my previous experience had been with that metal rod, and boy, I will tell you, once you have had that, your prayer schedule will be brought up to date, and I just said the heck with this. For anybody that doesn't know of this new technique, you know, forget it. It is mild, routine, and everybody should go ahead and use it. But, I think a lot of people who have undergone the previous treatment just figure, I'm just not going to do it. And you are right. This is something that everybody should do.

Dr. BENJAMIN. We clearly have an educational task in front of us to a whole generation of Americans who are turned off by this whole business.

Senator WEICKER. Yes; that's right.

My last question is how much validity is there to all the things I read as to new diet in terms of oat bran and those things being of value?

Dr. BENJAMIN. There clearly is something to diet when you look at the epidemiology of colon cancer patients. Studies have been done with Japanese-Americans. If you take someone in his native Japan, they do not get colon cancer, they get gastric cancer. If you look at a group of people in Hawaii, first generation, they begin to change the trend, and then if you put a group of Japanese-Americans in this country, they get colon cancer just like everyone else. The same thing has been shown for blacks from Rhodesia relocating in England.

There is clearly something about this environment. Whether it is red meat, the lack of bran, there are many, many potential causes, all of which are being vigorously looked into by people at NCI and

NIH. There is a great amount of research looking to the causes. But, if you want to be simplistic, there is something abut this environment that predisposes Americans to colon cancer.

Senator INOUYE. I have been told that there is a correlation with wealth and cancer, that the poor do not usually end up with colon cancer?

Dr. BENJAMIN. Well, that may be true for many countries, but those of us in Washington, for instance, the black population in this city has one of the highest instances of cancer of the digestive tract of anyplace, and certainly being poor in this city does not protect you from developing colon cancer or esophageal cancer. But, I think in many instances in the Third World that is true.

Senator INOUYE. Well, I thank all of you very much. It has been not only informative, but you have instilled in me a sense of urgency, and I can assure you that I will convey this sense of urgency to my colleagues.

Dr. FARRAR. May I make one final point?

PREPARED STATEMENT OF DR. ALVIN GELB

We want to thank you very much for the opportunity, Mr. Chairman and Senator Weicker, to appear before you. Dr. Alvin Gelb of the American College of Gastroenterology, regrets that he could not be here, and I did want to mention that for the record.

Senator INOUYE. Does he have a statement he would like to submit?

Dr. FARRAR. I think the statement has been submitted to Mr. Hall.

Senator INOUYE. Without objection, his statement will be made part of the record at this juncture.

Dr. FARRAR. Thank you very much.

Senator INOUYE. Thank you very much.

[The statement follows:]

STATEMENT OF DR. ALVIN GELB, AMERICAN COLLEGE OF GASTROENTEROLOGY

The American College of Gastroenterology is a professional organization representing 2,200 practicing physicians specializing in the care and treatment of persons with digestive diseases.

I am pleased to have the opportunity to be with you today, on behalf of the American College of Gastroenterology, to advise you of our support for increased funding levels for FY 89 for the National Institutes of Health, particularly the National Institute of Diabetes, and Digestive and Kidney Diseases, (NIDDK). The NIH is the world's finest biomedical research complex. The continued vitality of the NIH research enterprise is a crucial component of national efforts to improve the health and quality of life of all Americans.

OVERALL FUNDING CONCERNS (NIH)

The President's budget request for NIH for FY 89 is not even enough to maintain programs at their current operating level. The rising cost of conducting research means that an increase of about 14% will be required for FY 89 to support just the same level of effort as in FY 88. Factors contributing to increased costs of research include costlier materials, more sophisticated equipment, and a need for more highly trained staff. These factors are intrinsic to scientfic advancement; they do not include costs associated with general inflation.

For this reason we recommed that you provide funding for NIH at a level at least 20% over the current (FY 88) appropriation. We believe that $8.47 billion will adequately support expansion into areas of research which are ripe for further study, while at the same time, providing continued adequate support in current areas of inquiry. At the present time NIH is only able to support about 33 percent of approved individual research projects. The unfortunate result is that much valuable research -- especially novel ideas and promising new leads -- is lost.

Our funding recommendation of $8.47 billion for NIH would be adequate to accomodate an award rate of 41% for competing research project grants. This level will also be sufficient to provide appropriate increases in other critical funding mechanisms, including research training and NIH's intramural program. Ultimately, we believe that sufficient funding levels should be afforded to provide support of approximately half of all research projects -- the entire range of which consists of valuable research.

DIGESTIVE DISEASES

Diseases of the digestive tract are the leading cause of hospitalization and major surgery in the United States. Twenty million Americans are treated annually for chronic digestive diseases. Digestive diseases account for an estimated 200,000 absences from work each day. The monetary costs -- in terms of lost wages and reduced productivity, as well as health care expenditures and disability payments -- amount to approximately $50 billion dollars each year. The toll exacted in human pain and suffering is much greater.

Just a few examples serve to show what important practical applications are associated with the research which is fostered under the mandate of the Division of Digestive Diseases and Nutrition within the NIDDK.

As the committee is aware, an encouraging increase in survival rate has taken place in the area of liver transplantation. Prior to the advent of the immunosuppresant cyclosporin, a 35% survival rate was the norm; today it is about 70%. One day, liver cell transplantation may provide an alternative to liver transplants in selected instances. In recent animal studies, NIDDK-supported grantees successfully transplanted human liver cells by attaching them to collagen-coated, microscopic beads and administering cyclosporin, to avoid rejection.

Peptic ulcers threaten to become a very serious national problem because of continued and/or reoccurring episodes of bleeding which have often necessitated surgical intervention. The cause of ulcers which occur in the first part of the small intestine ("duodenal ulcers") has never been fully understood. Recently, NIDDK-supported efforts showed that patients with inactive duodenal disease have less of a bicarbonate and mucus secretion than normal subjects, in whom the secretion adequately protects the intestine's lining from normal levels of acid secreted in the digestive process. This finding may have application in efforts to determine the origin of duodenal ulcers and to understand more about the frequency of their occurrance.

We also applaud the participation of the NIDDK in efforts aimed at combating the deadly disease AIDS. The gut is the bodys largest immune organ. In the gut, a large number of lymphocytes (potent cells in the blood and lymph which seek out and destroy foreign substances) and other cells create a first-line defense at this prime point of entry for foreign organisms. In AIDS, the body's immune system is ravaged as the disease destroys these lymphocytes. Researchers have determined that abnormalities in gut immunity associated with AIDS heighten victims; risks of contracting other intestinally transmitted infections. In certain instances, normally non-threatening invasions may ultimately prove fatal.

Mr. Chairman, it is important to remember that for certain digestive diseases which are not usually life-threatening, progress cannot be measured in terms of lives saved. It can be measured in terms of reduction of human disability and suffering, and in associated monetary savings made possible by diminishing the necessity for surgery, and reducing losses in the workforce from these diseases.

NIDDK FUNDING CONCERNS

I am pleased to take this opportunity to express ACG's support for increased funding to support the NIDDK research portfolio. We have determined that approximately $680.5 million is the minimum amount needed to maintain the vitality of the NIDDK research program in FY 89. In addition to research project grants which exist as the cornerstone of the NIDDK research enterprise, several other areas are also of concern to us:

For quite some time, the American College of Gastroenterology has been concerned about the need to ensure an adequate supply of researchers in clinical and basic sciences. Over the past several years, the NIH training program has not kept pace with the increasing need to attract and retain the brightest students into the study of medicine. Consistent with the recommendations of the Digestive Disease National Coalition, of which ACG is a member, we believe that at least $13 million will be required to adequately support the NIDDK training program.

We also agree that approximately $14 million will be required to provide continued adequate support to the Centers Program, and to foster modest expansion into areas which have been identified by the National Digestive Disease Advisory Board as appropriate for increased emphasis.

Finally, we support adequate funding for other important programs within NIDDK, including the Epidemiology Data Base Program and the National Digestive Disease Education and Information Clearinghouse.

CONCLUSION

The exciting areas of inquiry now being fostered by NIDDK, and the areas of promise yet to receive attention, justify our recommended funding increase for this important institute. Funding for NIDDK for FY 89 at a level of $680.5 million will adequately support current services, and at the same time provide sufficient emphasis on new areas for which further inquiry is justified.

In past years, the committee has seen fit to provide sound funding increases for NIDDK. Congress has historically expressed its commitment to this area of research by appropriating amounts well in excess of administrations' proposals. Mr. Chairman, we thank you for your past efforts on behalf of NIDDK. We hope that you will continue to do all that is within your power to achieve a 28% increase in funding ($680.5 million) for NIDDK for FY89.

The American College of Gastroenterology would be happy to provide you with additional information on our position on digestive disease research funding.

STATEMENT OF DARRACOTT VAUGHAN, M.D., THE INTERSOCIETY COUNCIL FOR RESEARCH OF THE KIDNEY AND URINARY TRACT

Senator INOUYE. Our next panel consists of the following, Dr. Darracott Vaughan, representing the Intersociety Council for Research of the Kidney and Urinary Tract; Dr. Stuart A. Kleit, representing the National Kidney and Urologic Diseases Advisory Board; Dr. Jay Y. Gillenwater, of the University of Virginia Medical Center, representing the American Urological Association; Dr. David Shobe, executive director of the American Foundation for Urologic Diseases; and Dr. Billy S. Arant, Secretary-Treasurer of the American Society of Pediatric Nephrology.

Dr. VAUGHAN. Mr. Chairman, Senator Weicker, fellow committee members, we appreciate the opportunity to be here today, and since you have introduced the group, I would like each of them to speak to you individually from their various organizations, and then I will briefly summarize at the end.

I am Dr. Vaughan, representing the Intersociety Council for Research of the Kidney and Urinary Tract, from the New York Hospital, Cornell Medical Center.

What we have here today essentially are representatives from all the different groups, both lay and professional, that are interested in patients with kidney and urological diseases. We speak for the community, and prepared testimony has been submitted to you from each of the panel members for your consideration.

Senator INOUYE. All of your statements will be put in the record in full.

Dr. VAUGHAN. Thank you.

STATEMENT OF STUART A. KLEIT, D.D.S., M.D., CHAIRMAN, NATIONAL KIDNEY AND UROLOGIC DISEASES ADVISORY BOARD

Senator INOUYE. Our first contributor will be Dr. Stuart Kleit, who is chairman of the National Kidney and Urologic Diseases Advisory Board.

Dr. KLEIT. Thank you.

I am Dr. Stuart Kleit, chief of the renal section as well as associate dean for clinical affairs at Indiana University School of Medicine and chairman of the National Kidney and Urologic Disease Advisory Board.

I am honored to have this opportunity to testify to this committee on behalf of the Board. The Board was established in Public Law 92-463 and held its first meeting in June 1987. Its function, as outlined in its charter, is to develop a long-range plan to combat kidney and urologic diseases, providing specific recommendations for the utilization and organization of national resources in this struggle.

The Board has spent the last 10 months organizing to accomplish this task, setting work schedules and goals and initiating the collection of data.

The Board has divided into four basic committees and added over 400 expert consultants to the committees to provide a broad base of input into its recommendations. The Board's data committee is searching the medical literature, and existing Federal and other data banks for information on the extent, types and costs associated with kidney and urologic diseases.

The research committee is analyzing current and past research efforts and seeking clues to future areas which hold prospects for prevention and cure. It has major concerns about the few nephrologists and urologists who are receiving or are projected to receive research training in the future.

The technology transfer committee has several tasks. One is looking at current measurements and evaluations of quality of care, as well as access to care, coordination of public, patient, and professional education activities.

Also, non-M.D. and non-Ph.D. manpower needs in urology and nephrology are being evaluated, especially in light of the nursing shortage.

The hearings committee is in charge of planning and conducting the board's public hearings in Chicago, New York, Boston, Atlanta, Dallas, and Los Angeles. The first three hearings in Los Angeles, Dallas, and Atlanta each consisted of approximately 50 public witnesses who expressed concerns on a wide variety of patient and research problems. Their suggestions will be collated and used in developing our final recommendations to you.

Parenthetically, I might add, it gave us an appreciation of what you go through every day, Senator.

The Board is concerned by the continued financial problems associated with research funding. Currently, individual research grants are automatically cut by 10 percent, and the centers program, which you initiated last year, by 15 percent. Furthermore, young investigators in particular but all investigators are suffering from a decreased funding rate of 26 percent of approved grants. This steady erosion of research funding will, if continued, have both long- and short-term consequences. As those responsible for producing a long-range plan, we are concerned that short-term budgetary requirements may affect our long-term abilities to solve the problems of kidney and urologic diseases.

We request that as you deal with your difficult task, you take into account these potential long-term effects.

The final report of the Kidney and Urologic Disease Advisory Board will be available in February 1990. In the interim, the Board makes the following recommendation to the committee. The Board recommends that the Congress provide funds to support kidney and urologic disease research at the National Institute of Diabetes, Digestive and Kidney Disease at $680 million as recommended by the ad hoc group for medical research funding. Recommendations for programs and funding levels for other relevant Federal agencies and private sector initiatives will be included in the Board's long-term report.

PREPARED STATEMENT

I want to close by thanking the committee for its past and continuing interest in biomedical research and to the prevention and treatment of kidney and urologic diseases. In addition, your support of patient care in this arena through Medicare has made it possible for many to continue living who would otherwise have died.

Thank you very much.

[The statement follows:]

STATEMENT OF STUART A. KLEIT

I am Stuart A. Kleit, D.D.S., M.D., Chief of the Renal Section as well as Associate Dean for Clinical Affairs at the Indiana University School of Medicine and Chairman of the National Kidney and Urologic Diseases Advisory Board. I am honored to have the opportunity to testify on behalf of the Board to this Committee.

The Board was established by PL 99-158 to develop a long-range plan to combat kidney and urologic diseases providing specific recommendations for the utilization and organization of national resources in this struggle. The Board has spent the last 10 months organizing to accomplish its task, setting work schedules and goals, and initiating the collection of data. The Board has divided into four basic committees and added expert consultants to the committees to provide a broad base of input into its recommendations.

The Board is also holding public hearings in Chicago, New York, Boston, Atlanta, Dallas, and Los Angeles to obtain recommendations that will be used in developing our final report.

In addition to the meetings of the Board, its committees and subcommittees, and the hearings, the Board has requested and received reports, papers, and data from 40 volunteer health agencies, professional societies, and state and local governments. It has also commissioned 40 state-of-the-art research and clinical reports on various kidney and urologic diseases from benign prostatic hyperplasia to transplantation. Many of these activities are being provided at no cost to the Government. A total of 400 people are currently at work on one or another of the Board's activities. By December, this number should exceed 600. By the time the report is published, it will have been reviewed and commented upon by many more.

Our early data indicate that the true cost of kidney and urologic diseases far exceeds the $14 billion a year in direct medical costs that have been quoted in the past. The toll of these diseases on the patients' quality of life and emotional health is even higher.

End-stage renal disease (ESRD) leads to treatment that causes patients to lose 12 to 18 hours of productive time per week. If patients were receiving minimum wages, this time represents a loss of close to $7 billion in income per year. The Federal Government directly expends nearly $3 billion on the treatment of more than 93,000 persons with ESRD annually. It is also important to recognize that this burden will increase since the number of patients developing ESRD is increasing a rate of 10 percent per year.

Kidney transplantation is an option for some ESRD patients. Including surgery, the first year of medical care for a transplant patient averages $45,000, compared with $25,000 per year for dialysis.

Glomerulonephritis is an inflammation of the glomeruli, the part of the kidney where filtration takes place. The disease, which is estimated to affect more than 1 million Americans, is the primary diagnosis for 22 percent of all ESRD patients.

Kidney disease due to diabetes mellitus (KDDM) is the leading cause of death for the Nation's estimated 6 million diabetics; approximately 30 to 40 percent of all insulin-dependent diabetic patients develop progressive renal disease leading to permanent kidney failure. About one-third of patients entering ESRD programs have diabetic nephropathy. This disorder is becoming an increasing problem in our Native American population.

Polycystic kidney disease (PKD) is an inherited disorder leading to irreversible renal failure. An estimated 250,000 to 500,000 Americans are affected by PKD, which is characterized by the progressive growth of cysts in the kidneys. About 10 percent of ESRD patients have PKD.

Kidney and urinary tract stones lead to more than 750,000 physician visits annually. Treatment costs vary with the technique used--surgical costs average $9,000, while extracorporeal shock wave lithotripsy is somewhat less expensive.

Urinary tract infections are the second most common bacterial disease treated by physicians, and at least 8,000 patients die each year from kidney infections.

Cancers of the prostate, bladder, kidney, and testicles were diagnosed in 156,300 Americans in 1987; during the same year more than 47,000 patients died.

Benign prostatic hyperplasia affects close to half of all men by age 50, and nearly 100 percent by age 80. The total cost of diagnosing and treating this disorder exceeds $1 billion per year.

Urinary incontinence afflicts 8 to 15 million Americans, of whom only about one-half are age 65 or older. The cost of urinary incontinence in the over 65 population alone is $8 billion per year.

Painful bladder disease, also called interstitial cystitis, causes scarring and stiffening of the bladder wall and decreased bladder capacity, resulting in an almost constant, urgent need to urinate. In the United States, an estimated 44,000 to 90,000 patients have interstitial cystitis with an estimated treatment cost of at least $400 million per year.

Neurogenic bladder dysfunction is often associated with urinary tract infections. This interference with the nerve supply to the bladder occurs in 50 percent of patients with diabetes, 10 to 15 percent of patients with cerebrovascular disease, 50 to 80 percent of patients with multiple sclerosis, and 25 to 75 percent of patients with Parkinson's disease. Most patients with spinal cord injuries have voiding dysfunction.

Male erectile dysfunction, or impotence, affects between 10 and 35 percent of the adult male population and often begins in the mid-30's. This chronic problem most often occurs in the absence of serious medical problems. Although it is difficult to estimate the cost of this problem, the emotional impact on the patient is considerable.

Male infertility is one of the most common chronic physiologic problems in young people. In addition to the annual cost of $300 to $500 million, this condition causes a great deal of emotional suffering.

Congenital anomalies often are associated with kidney and urological diseases. For example, voiding dysfunction and/or incontinence occurs in 80 percent of patients with myelomeningocele, or spina bifida.

In all these areas, continued needs for research; translation of research discoveries to clinical care; and patient, physician, and public education are present. The Board is currently evaluating those needs.

The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) is the lead Federal agency for research on the prevention, early diagnosis, and treatment of kidney and urinary tract diseases.

The Board is concerned by the continued financial problems associated with NIDDK's research funding. Currently, individual funded research grants are automatically cut by 10 percent, and the center programs by 15 percent. Furthermore, young investigators in particular but all investigators in general are suffering from a decreased funding rate of 26 percent of approved grants. Funding scores have dropped from 220 to 145.

This steady erosion of resource funding will, if continued, have both long- and short-term consequences. These include a lack of translation of past basic research findings into clinical problem solutions, a freezing of high-cost technology due to failure to pursue low-cost alternatives, and ultimately, a collapse of our basic science knowledge base, which requires continued replenishment. As those responsible for producing a long-range plan, we are concerned that short-term budgetary requirements may affect our long-term abilities to solve the problems of kidney and urologic diseases.

Additional Federal agencies have kidney and urologic disease-related activities within their purview, and each agency has an ex officio member who serves as a representative on the Board. These agencies include the National Institute of Allergy and Infectious Disease (NIAID), National Cancer Institute (NCI), National Heart, Lung, and Blood Institute (NHLBI), National Institute on Aging (NIA), Centers for Disease Control (CDC), Indian Health Service (IHS), Health Care Financing Administration (HCFA), Health Resources and Services Administration (HRSA), and Food and Drug Administration (FDA). Recommendations for programs, funding levels, and program plans for these and other relevant Federal agencies and private sector initiatives will be included in the Board's long-range plan.

The Board's congressional authorization only lasts through September 1988, and we anticipate that Congress will reauthorize the Board. It is critical that NKUDAB be permitted to complete its long-range plan in order to present its fiscal and programmatic recommendations. In the interim, the Board recommends that:

- Congress provide funds to support kidney and urologic disease research at NIDDK at $680 million, as recommended by the ad hoc group for medical research funding (the NIDDK Coalition).

I want to close by thanking the Committee for its past and continuing interest in biomedical research into the prevention and treatment of kidney and urologic diseases.

Senator **Inouye**. I thank you very much, Doctor.

You have listed several exotic types of diseases here, and you have some description, but on one there is none.

What is benign prostatic hyperplasia?

Dr. **Kleit**. The gentlemen around me probably know more about it than I do. Benign prostatic hypertrophy or hyperplasia is an extraordinarily common thing that affects males. It is enlargement of the prostate, and if I remember the numbers that they fed me correctly, it involves about 70 percent of the population by age 70. It leads to obstruction of the urinary tract and results in prostatectomy. It has an extraordinarily high cost to the population since it involves a large number of elderly males and is extraordinarily common.

At this time, the only way of treating it is through surgery. What we really need is more research in this area to come up with some type of medical therapy which would reduce the need for surgery in these patients.

Senator **Inouye**. It says here that by age 80, nearly 100 percent?

Dr. **Kleit**. Yes, sir.

Senator **Inouye**. Is this what we are looking forward to?

Dr. **Kleit**. I guess if we are male, if we can last that long, we are looking forward to that. It is an extraordinary problem, and one that is so commonplace that it is ignored; because it occurs so frequently, it doesn't contain some of the excitement that maybe some other things like transplantation might evoke from us, and it therefore tends to be a little bit ignored by everybody who discusses funding and things like that.

But I think we had better pay attention to it, and as I get older, I get a little more worried.

Senator **Inouye**. I can assure you that I am going to be very interested in this. I was hoping to live for another 20 years. With this facing me, I might reconsider that.

Dr. **Kleit**. I wouldn't reconsider on that basis alone, Senator.

Senator **Inouye**. Thank you.

STATEMENT OF DR. DAVID D. SHOBE, EXECUTIVE DIRECTOR, AMERICAN FOUNDATION FOR UROLOGIC DISEASE, INC.

Dr. **Vaughan**. The next speaker would be Dr. David Shobe, executive director of the American Foundation of Urologic Disease.

Senator **Inouye**. Dr. Shobe.

Dr. **Shobe**. Mr. Chairman, our new foundation, established by the American Urological Association just last year, is located in Baltimore. As an economist, you will be hearing more from the foundation over the next months and years as we begin to assess the real economic costs of the diseases of the genitourinary system, including the one which you just heard about, prostatic enlargement, which also results in prostatic cancer, the second leading cause of cancer in men.

Today millions of Americans must confront these diseases, unfortunately without the benefit of the massive research dollars which this committee has directed toward other diseases. The foundation will continue the work begun by the American Urological Association in the midseventies of training young researchers in order to build a broad and viable research base, and in that regard, we welcome the contribution of Congress through the creation and funding of the O'Brien Kidney and Urology Specialized Centers of Research. These few centers represent a beginning. More should be established as quickly as possible.

This committee assuredly recognizes the importance of comparable research bases established on behalf of cancer, heart disease, arthritis, diabetes, and other disease related research areas.

While the foundation is very young, it will attempt to be prescient relative to promising research areas, through the counsel of the American Urological Association's Research Committee and in collaboration with the Division of Kidney, Urologic and Hematologic Diseases of NIH.

Getting back to the economics of these diseases, let me take incontinence, for example, which affects an estimated 3 million Americans over age 65, and a large proportion of the population under age 65. In this area not only NIH but also HCFA should be paying more attention to health cost containment strategy for a dysfunction which is responsible for an estimated one-third of the nursing home care costs in this country, or $8 billion a year.

Senator INOUYE. One-third?

Dr. SHOBE. One-third of the nursing home care costs in this country are caused by incontinence yes, sir.

Joe Califano, former Secretary of Health and Human Services, recently remarked that among research in diseases affecting the aging, incontinence has been especially shunned.

Senator INOUYE. Can you describe incontinence?

Dr. VAUGHAN. Incontinence is involuntary loss of urine, loss of control of voiding, normally leading to wetness, and many times the reason perfectly otherwise normal people, elderly people, have to be hospitalized or put in nursing homes is because of the social distress of this problem. Research into this has been woefully neglected, and often the people are shunted out, without a proper evaluation whereby drug therapy is often available which can solve the problem without the need for institutionalization.

Senator INOUYE. I notice television now advertising adult diapers. Is that what it is?

Dr. VAUGHAN. That is correct. That is a solution which temporizes, it doesn't solve the overall problem. It is just a social way of addressing it.

What we need, of course, is to find the etiology of the leakage in these patients.

Dr. SHOBE. Another urologic disorder which you just heard about, Senator, prostatic enlargement, has been characterized by NIH as epidemic since it does affect apparently some 75 percent of American males over age 50. The present estimated cost of treating this disease ranges as high as $5 billion annually and will undoubtedly escalate as the numbers afflicted mount over the next decade.

A concentrated research effort at this time to identify the causative factors of prostatic enlargement could result in tremendous health cost savings, especially, as my colleague indicated, they could lead to preventive measures. Research findings leading to improved medical management of as few as 20 percent of patients seeking help for this disease could save an estimated $1 billion a year in health care costs.

HCFA and other health insurers should also be paying greater attention, I believe, to urinary tract infections, especially the some 900,000 each year which are hospital related. This should be a red flag to both public and private insurers to press for answers to this major urologic problem which results in an added 4 to 5 days of hospitalization per patient.

PREPARED STATEMENT

I thank the committee for its indulgence. The American Foundation for Urologic Disease will be providing data to this committee over the course of the next year to support the need for a great focus of the biomedical research community on the little understood and underresearched areas of the genitourinary system.

Thank you, Mr. Chairman.

Senator INOUYE. Thank you very much, sir.

[The statement follows:]

STATEMENT OF DAVID D. SHOBE

My name is David Shobe. I'm the Executive Director of the American Foundation for Urologic Disease, located in Baltimore.

I appreciate being able to introduce the new American Foundation for Urologic Disease to you and the House Appropriations Committee. You will be hearing more from us over the next months and years as we begin to assess the real economic costs of the diseases of the genitourinary system, and as we reflect on the best means to try to reduce these costs--basic and clinical research, patient and public education, and more rapid transfer of research findings to the medical and surgical management of these disabling diseases which afflict so many Americans.

Today, millions of Americans, young and old, must confront these diseases without the benefit of the massive research dollars which this Committee has directed toward other diseases, and without the public education campaigns which have encouraged us to seek medical help for our hypertension, arthritis, cancer, diabetes and alcohol and smoking problems.

The Foundation will continue the work begun by the American Urological Association (AUA) in the mid-1970's of training young researchers in order to build a broad and viable research base. The admirable achievement by the AUA in its selection of candidates for its research scholars program so as to have over 95 percent of its graduates remain in academic research and teaching is a record which the Foundation will attempt to emulate.

We welcome the contribution toward the creation of an interdisciplinary research base by the creation and funding of the O'Brien Kidney and Urology Specialized Centers of Research. This is a beginning and should be advanced as quickly as possible through this Committee's recognition of the importance of comparable bases in cancer, heart disease, arthritis, diabetes, digestive diseases and other disease-related research areas.

While the Foundation is young, it will attempt to be prescient relative to promising research areas through the counsel of the AUA's Research Committee and in collaboration with the Division of Kidney, Urologic and Hematologic Diseases of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) of the National Institutes of Health.

For example, the numbers of persons afflicted by incontinence--an estimated three million Americans over age 65--should be sufficient reason for this Committee to ask the Institute on Aging to substantially expand its research in this area, and to suggest to the Health Care Financing Administration that it should be paying more attention in its health cost containment strategy to a dysfunction which is responsible for an estimated one-third of the nursing home care costs in this country.

Another urologic disorder, benign prostatic hyperplasia (BPH), or enlargement of the prostate, has been characterized by NIH as an "epidemic", affecting some 75 percent of American males over age 50. The present costs of treating this disease will undoubtedly escalate as the numbers afflicted mount over the next decade. A concentrated research effort at this time to identify the causative factors of BPH could thus result in tremendous health cost savings, especially if they lead to preventive measures.

HCFA and other health insurers should also be paying greater attention to urinary tract infections, especially the some 900,000 each year which are hospital related. This should be a red flag to insurers to press for answers to this major urological problem which results in an added 4-5 days of hospitalization per patient.

I thank the Committee for its indulgence. The American Foundation for Urologic Research will be pleased to work with the Committee in any way to sharpen the focus of the biomedical research community on the little understood and under-researched areas of the genitourinary systems.

STATEMENT OF BILLY S. ARANT, JR., M.D., PROFESSOR OF PEDIATRICS AND DIRECTOR, DIVISION OF PEDIATRIC NEPHROLOGY, UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL SCHOOL, AND SECRETARY-TREASURER, AMERICAN SOCIETY OF PEDIATRIC NEPHROLOGY

Dr. VAUGHAN. The next speaker will be Dr. Billy Arant, representing the American Society of Pediatric Nephrology.

Dr. ARANT. Mr. Chairman, my name is Billy S. Arant, Jr. I am professor of pediatrics and director of the division of pediatric nephrology, University of Texas Southwestern Medical School in Dallas, TX. I also serve as secretary-treasurer of the American Society of Pediatric Nephrology, and it is that organization for which I speak today.

I would like to raise your awareness of the problems encountered in training and funding research for pediatricians who wish to train and take care of children who suffer from kidney disorders. There are approximately 220 pediatric nephrologists in academic institutions in the United States currently providing medical care to children with kidney disease. Effectively, that is 1 pediatric nephrology for every 200,000 children. By contrast, there is 1 general nephrologist for every 60,000 adults.

In addition to the relatively fewer pediatric nephrologists, an increasing number of kidney related problems in children has increased the clinical burden on each pediatric nephrologist employed. Consequently, a large segment of the U.S. population is being underserved, even denied access to such specialized medical care. There are 10 States which have no such available medical care, and 11 States, including your own, which has only one person to deliver that care for all the children.

The pediatric nephrologist is a pediatrician who has spent 3 years in training and 3 additional years in training just for kidney disease to take care of children with kidney problems. In the past 20 years, the development of new technology, adapting technology devised for adults such as dialysis and then transplantation, is now available for children, even newborn infants. We can even provide care for premature infants that are born with kidney disease or poorly functioning kidneys or whose kidneys are damaged irreversibly during the care, intensive care that has increased the survival rate of premature infants.

This has created a large new segment of chronically ill children for which care must be provided.

Many of these babies are born and require a large amount of time spent by an individual physician. It often takes one physician up to 50 percent of his time to provide for one child in the first several months of life. Alternatively, there is very little compensation for this because insurance carriers and State programs and Medicare do not provide for these children in the first 3 months of life, and some of them are uninsurable because they have so-called preexisting disease.

Eighty percent of the causes of end stage kidney disease, kidney failure in adults, come from causes that begin in childhood, like diabetes, and there are no federally funded programs targeting children with kidney disease that will develop into kidney failure in adults.

We have a problem with manpower and training. A previous witness has alluded to, in gastroenterology, the need for training for research in digestive diseases. You asked him additional questions. There are approximately 1,000 pediatricians completing training each year in this country. Forty percent elect subspecialty training, but fewer than 10 of these 1,000 elect to train in the discipline of pediatric nephrology. Currently, there are four that are funded by the National Institutes of Health.

By 1992 there will be 125 positions needed, dictated by the demand for clinical care, and approximately 30 people will have been trained by that time to fill that need, leaving at least 100 positions unfilled.

PREPARED STATEMENT

We recommend that there be support for training and funding at the National Institutes of Health, specifically designated for pediatric nephrology. We ask that the NIH funding language support specific research proposals to improve our understanding of the disease mechanisms in the kidneys of the infants and children; support multicenter studies to identify diseases that begin in childhood; and devise treatment to prevent kidney failure in adults. We also ask that in your deliberations the clinical demands for the needs of children with kidney disease be given consideration, and we thank you for this time.

[The statement follows:]

STATEMENT OF BILLY S. ARANT, JR.

There are approximately 220 pediatric nephrologists in the United States currently providing medical care to children with kidney disease. Effectively, there is one pediatric nephrologist for every 200,000 children. By contrast, there is one general nephrologist for every 60,000 adults. In addition to relatively fewer nephrologists, an increasing number of kidney-related problems, which are complications of advanced treatments for other diseases in children such as cancer and of improved survival of children in pediatric and neonatal intensive care facilities, has increased the clinical burden for each pediatric nephrologist still involved in patient care. Consequently, a large segment of the U.S. population is now underserved and may even be denied access to such specialized medical care in the very near future.

The U.S. Government now spends nearly $3.0 billion annually through Medicare to treat end-stage renal disease, mostly in adults -- 80% developed kidney failure because of a disease, like diabetes, which began during childhood. To date, no federally-funded research programs have been directed towards preventing these diseases; however, many programs have been funded to develop new treatment strategies for kidney diseases in adults which began in childhood--too late, perhaps, to interrupt the progression of renal injury. While these programs are important, programs developed to identify the mechanisms of kidney damage from these diseases during childhood would be more cost effective and with measures for intervening earlier to lessen the growing public burden of paying for the treatment of adults with kidney failure.

In a recent survey conducted by The American Society of Pediatric Nephrology, 93% of Chairman/Program Directors of U.S. medical school-affiliated pediatric training programs confirmed the manpower shortage extant already in pediatric nephrology. This manpower shortage will worsen during the next five years. At the present time, approximately 40 full-time positions for pediatric nephrologists in the United States remain unfilled. There are 10 states (AK,ID,KS,ME,MS,MT,NM,ND,WV,WY) for instance, which have no resident pediatric nephrologist and must depend upon the resources of neighboring or distant medical centers to provide specialized consultation and care for their young citizens; 10 other states (AZ,DE,HI,NE,NH,NV,OR,RI,SD,VT) have only one pediatric nephrologist. The projected need for 125 additional pediatric nephrologists in the United States by 1992 is considered a conservative estimate.

There are 33 training programs in the United States certified to train pediatricians for careers in pediatric nephrology. The duration of such training is three years of which half must be spent in research. At present, there are 46 trainees in 17 of the 33 programs; however, only two-thirds of these trainees will be eligible to accept unfilled academic positions in the United States. The others are foreign nationals and must return to their countries of origin. During 1988, only eight individuals will be available to fill the more than 40 open positions. About 20 other trainees will complete fellowships during 1989 and 1990. At the current rate of training there will be more than 100 positions in pediatric nephrology still unfilled by 1991. According to the American Board of Pediatrics, 40% of the 1,000 pediatricians completing training each year choose subsequent training; however, <0.5% of them select pediatric nephrology. While more than 30% of U.S. children with kidney disease are Black, there are only two Black pediatric nephrologists in this country.

Some foreign physicians, fully-trained in pediatrics in their national countries or in the U.S., have completed pediatric nephrology training successfully in these United States programs. These individuals are ineligible to fill the urgent need for additional pediatric nephrologists in the United States because of an inability to obtain permanent immigrant visas without which medical licensing and academic appointments are precluded. With current restrictions by U.S. immigration laws, fully-trained, foreign pediatric nephrologists are not permitted to work temporarily in or to immigrate to this country. Due to the escalating clinical demand placed upon the dwindling number of pediatric nephrologists currently engaged in patient care, the United States faces a critical manpower shortage within the next 10 years when it will no longer be able to meet the medical needs of its children with kidney diseases who will be denied the treatment made available to adults.

For those few individuals making the commitment for an academic career in pediatric nephrology, the likelihood of being successful in obtaining extramural funding for research is impaired greatly by the clinical demands placed upon the individual. As a result of concerted efforts by the American Society of

Pediatric Nephrology and the National Institutes of Health, funding for R01 grants submitted by pediatric nephrologists has increased from 12 in 1982 to 32 in 1986. However, this compares unfavorably with the total number of grants given to adult nephrologists which numbers 323. It should be pointed out that this proportion remains unfavorable to pediatrics even if adjusted for the difference in number between university-based adult and pediatric nephrologists. As long as the measure of academic productivity and job success remains the number of papers in scientific publications and the amount of competitive funding secured for research projects, the prospects for any pediatric nephrologist with major clinical responsibilities being promoted and awarded tenure on medical school faculties remains unlikely.

To address these problems, there must be increased federal support for training pediatricians to become nephrologists, as either basic or clinical investigators in the area of pediatric nephrology. Specifically, there should be:

1) Three (3) centers of excellence for both training and research in pediatric nephrology established and funded by the National Institutes of Health. Within these centers, a critical mass of research activity could be organized for training and equipping post-doctoral fellows with research skills to conduct their own independent research pursuits. Such would not be possible to establish at each of the 33 training programs. One mechanism proposed to fund these new training programs without additional appropriation is for the National Institutes of Health to commit 0.5% of current training funds from each of the institutes which presently fund research in renal disease. Funding for research efforts of individuals working at the center or in collaborative arrangements at other centers would require additional funds for the NIH or a decision by the NIH to rebudget a portion of existing funds to alleviate the critical and peculiar needs identified for pediatric nephrology programs. The responsibility for the development and oversight of such a program would fall to the NIDDK or NICHD since the latter institutes have a concern for scientific investigation in renal development and disease and the long term well being of children. Competing applications for the funding of these centers should be reviewed by Special Study Sections comprised of pediatric nephrologists.

2) Specific grant programs (RFAs) funded by the National Institutes of

Health developed to support relevant basic and clinical research for pediatric nephrology. To provide competent, informed review of these and other research applications to the NIH, at least one pediatric nephrologist who has demonstrated research competence already should be appointed to each NIH Study Section which reviews applications submitted for studies related to developmental and pediatric aspects of kidney function and disease. These include, but are not necessarily limited to, General Medicine B, Cardiovascular-Renal, Experimental Cardiology, Human Embryology and Development, and Urology Study Sections.

3) Expanded support for multicenter clinical studies on the etiology and therapy of kidney disease in children. Because of the relatively low incidence of each type of pediatric kidney disease, no one center will have an adequate number of patients to study a particular disease or its treatment. Pediatric nephrologists through the International Study of Kidney Diseases in Children and the Southwest Pediatric Nephrology Study Group have demonstrated previously an ability to work together to this end; both groups have contributed importantly to our current understanding of kidney diseases in children.

4) An effort made to retain current pediatric nephrologists in their present capacities. The overall manpower needs of pediatric nephrology cannot be met if there continues to be significant attrition from the subspeciality. Reimbursement for clinical skills would allow salaries to become similar to other clinical subspecialists. Moreover, consideration should be given to the development of a proposal which would provide funds for pediatric nephrologists currently employed at academic institutions, to redefine or develop their investigative skills. Individuals previously trained in research techniques but who have functioned as clinical pediatric nephrologists for the past 10-15 years no longer have the research tools and academic skills to compete in the more sophisticated environment of molecular biology. This funding would be possible under currently structured Senior International Fellowships (Fogarty} (F06) or a Senior Scientist Research award (F35).

4) Direction given the U.S. Immigration and Naturalization Service to issue permanent immigrant visas to a limited number of qualified foreign pediatric nephrologists. This one-time provision to relieve the urgent need which cannot be met by U.S. resources should be limited to not more than 40 pediatric

nephrologists who are eligible for and pass the examinations given by the American Board of Pediatrics and its Sub-Board of Pediatric Nephrology within three years of beginning work in the United States. These individuals must have academic faculty appointments at a U.S. Medical School when the application for a visa is submitted. Precedence for such an exception to immigration quotas can be found for other occupations identified to have large unmet needs in this country.

SUMMARY

The manpower crisis in pediatric nephrology is of such magnitude that if immediate steps are not take to reverse the trend established over the past five years in recruiting pediatricians for training in the subspecialty and in halting the attrition of experienced pediatric nephrologists to less stressful and more satisfying jobs, specialized medical care for infants and children with kidney disease will not be available in many geographic regions in the United States--regardless of need or the availability of money to pay for it.

2. Specific recommendations include:
   a. NIH funding for research/training centers for pediatric nephrology
   b. NIH funding of specific research proposals (RFA) for pediatric nephrology to improve the understanding of normal and disease mechanisms in the infant's and child's kidneys.
   c. NIH support of multicenter clinical studies to identify prevalence and test new treatments for children's kidney diseases
   d. NIH support for retraining career pediatric nephrologists with modern research skills
   e. Providing permanent visas to 40 qualified foreign pediatric nephrologists to fill urgent clinical need for children with kidney disease.

Senator INOUYE. Thank you very much.

Two years ago, at the urging of your colleagues in pediatrics, we assisted in the establishment of a pediatric emergency service project. It was suggested that most physicians are trained to assist adults faced with accidents and such but are not trained to assist little babies.

You have noted in your testimony that there is 1 general nephrologist for 60,000 adults and 1 pediatric nephrologist for 200,000 infants.

The general nephrologist has difficulty dealing with the infants?

Dr. ARANT. Yes, sir; much of the treatment is related to body size, and the patients who require the most time intensive expertise are these newborn infants and small children for whom the specialist in internal medicine has not been trained. In most circumstances the physician is appropriately unwilling to take on that task. They are of help to us, and in areas where there is no pediatric expertise, the internist, nephrologist, will make every effort to provide that care. We try to help them as much as possible. We provide care for children from 500 to 700 miles away. It is very difficult for the patient to make frequent trips, but in some locales there is just no place to take care of these children.

Senator INOUYE. I suppose the problem you have cited for nephrology would exist in just about every other specialty, will it not?

Dr. ARANT. It exists in every other specialty, but in pediatric nephrology, I think we are talking about inability to deliver medical care for children that is available to adults, and that has been limited by the number of trained physicians who are available to provide that care.

Senator INOUYE. I notice in your prepared testimony you advocate granting permanent visas to 40 foreign trained nephrologists?

Dr. ARANT. Yes; there are 48 positions currently unfilled in this country, and the need is great, and it is because of clinical demand.

With only 8 people, approximately, to fill these 48 positions, there are 40 positions that will be unfilled. There is the projected need by a conservative estimate of an additional 100 positions.

Senator INOUYE. Are there applicants for this?

Dr. ARANT. I beg your pardon?

Senator INOUYE. Applicants for this visa?

Dr. ARANT. There will be applicants for this.

There are many people who have come to this country on a J type visa who have had the same training I have had, the same training we provide American graduates. But these people cannot have their visa status changed and must return to their countries of origin. Many of them find that there is an excess, as in Europe, of pediatric nephrologists. In other countries, there are no programs available to help them implement programs for children, so they would like to immigrate to this country, but it will have to be regulated to those who are qualified and trained in the American system. Those that have the same training as American graduates would have to take a prequalifying examination.

Senator INOUYE. We would like to help you, if you can advise us as to where the list is.

Dr. ARANT. We will provide that for you.

Thank you very much.

Senator INOUYE. Thank you, sir.

STATEMENT OF DR. JAY Y. GILLENWATER, UNIVERSITY OF VIRGINIA MEDICAL CENTER, AMERICAN UROLOGICAL ASSOCIATION, INC.

Dr. VAUGHAN. The next speaker is Dr. Jay Y. Gillenwater, representing the American Urological Association, the American Association of Clinical Urology.

Senator INOUYE. Dr. Gillenwater.

Dr. GILLENWATER. Mr. Chairman, I am Jay Gillenwater, chairman of urology at the University of Virginia Medical Center, member of the American Urological Association's executive committee, member of the advisory council of the National Institute of Diabetes, Digestive and Kidney Disease.

I am presenting this testimony on behalf of the American Urological Association and the American Association of Clinical Urologists, the Society of University Urologists, the American Board of Urology.

Mr. Chairman, the magnitudes of the problems of urologic diseases in terms of death, morbidity, suffering, and cost have not been appreciated in national discussions on health care matters. When we are able to generate the data, largely through the kidney and the urology advisory board which this committee strongly supports, I am confident that it will show that urologic diseases will have the smallest research and training support of any group of diseases at the National Institutes of Health relative to cost and to health consequences.

Urinary incontinence, which has already been mentioned, which is an inappropriate loss of urine, is a problem that affects about 10 million Americans and about 50 percent of the people over age 65. It is one of the major reasons for the elderly being admitted to nursing homes, and the cost is estimated at about $8 billion per year.

Prostate enlargement, which you have already talked about, results from a hormone being secreted, one or more, from the testicle, which have not been identified. It is not testosterone, there are two research centers working on that now, but if you remove the testicle from someone, they do not get enlargement of the prostate. There has been a recent report out of China where when you go into the monasteries, at whatever age, they remove the testicle. None of these people had enlargement of their prostate.

Senator INOUYE. That is a high price to pay.

Dr. GILLENWATER. I do not think that is going to be the cure.

Senator INOUYE. Thank you.

Dr. GILLENWATER. Each year, about 250,000 men, including President Reagan, need a prostatectomy to remove the prostate. Now, we are talking about benign enlargement of the prostate. It is not prostate cancer. There are two diseases that affect the prostate. One is it just continues to grow out throughout life, and that is called benign prostatic hypertrophy. A separate disease is the prostate can get cancer, which is one of the more frequent cancers.

Urogenic bladder dysfunction is where the brain is not able to tell the bladder when to empty or to sense when it is full, and this is a very common disease, particularly in people that have other defects or neurologic problems.

Male impotence is a chronic problem affecting between 10 and 35 percent of the adult male population.

Male infertility, about 15 percent of American couples are infertile. The causes for the infertility is on the male side about half the time.

There is a disease called interstitial cystitis which is a poorly understood group of complexes with people that have a very painful bladder. When their bladder starts to fill, they get pain and have to empty their bladder quite frequently.

The report language accompanying the fiscal year 1988 appropriations bill requested a report on urologic research training. A final report will be completed next year. The preliminary observations are that this is the least number of research trainees studying urologic diseases of any discipline at the National Institute of Health, and that the lowest amount of NIH support of any specialty group of diseases is going to urologic diseases.

This year the NIDDK funded six George O'Brien centers at $4 million, instead of the $6 million which was required for appropriate levels of activity. On top of this, the centers took an additional 15-percent cut.

We recommend doubling the number of the O'Brien Centers which is based on experiences with other diseases, in particular, the GI disease. This would take 6 million new dollars; to fully fund the existing ones would take an additional $2.5 million.

For the six funded O'Brien Centers we had 15 applications with only a 3-month lead time. I was a member of the committee that selected the grants, and I can attest to the fact that all 15 should have been funded for their scientific excellence.

There is a documented need to develop research trained urologists and recruit scientists to develop research in urologic diseases. The NIDDK now has only two grants in urology, with a total of three trainee slots per year. The overall research budget for urology is less than 10 percent of our division, and only 2 to 3 percent of the NIDDK budget.

There are a half million patients admitted with prostate disease each year, with $2 billion in direct costs. So, there is clear documentation of a need to have more people training to try to stop urological diseases.

One mechanism to accomplish this has been developed already by NIDDK which would encourage existing and newly proposed centers to support a young investigator for up to 100 percent of his time to participate in a training program for 3 years. In addition, NIDDK allocates a small amount of funds for pilot projects undertaken by these trainees. The salary range is up to $70,000, and the cost of pilot projects up to $25,000. So it would cost $100,000 per center.

PREPARED STATEMENT

We propose that 10 training centers be funded for these trainees. These would be called the George O'Brien Centers Trainees Award so that the number of trainees in urology would increase from 3 to 13.

Thank you very much, Senator.

[The statement follows:]

STATEMENT OF JAY Y. GILLENWATER

I am Jay Y. Gillenwater, M.D., Chairman of the Department of Urology at the University of Virginia Medical Center and member of the American Urological Association's Executive Committee and of the Advisory Council of the National Institute of Diabetes, Digestive, and Kidney Diseases (NIDDK). I am presenting this testimony on behalf of the American Urological Association whose membership of 6,200 represents the vast majority of American urologists. I also represent the American Association of Clinical Urologists, the Society of University Urologists, and the American Board of Urology.

Mr. Chairman, the magnitude of the problems of urological diseases in terms of death, morbidity, suffering, and costs has not been appreciated in the national discussions on health care matters. When we are able to generate the data largely through the Kidney and Urology Advisory Board, which this Committee strongly supports, I am confident it will show that urologic diseases will have the smallest research and training support of any group of diseases at the National Institutes of Health, relative to costs and health consequences.

IMPACT AND SCOPE OF UROLOGIC DISEASES

Urinary Incontinence is a problem that afflicts around 10 million Americans, at lest 50% over the age of 65-years-old. Incontinence is one of the major reasons for the elderly being admitted to nursing homes. Cost of incontinence in the elderly alone is $8 billion per year in the United States.

Benign Prostatic Hyperplasia. Enlargement of the prostate with resultant obstruction of urine flow affects 50% of men by age 50 and nearly 100% by age 80. Prostatectomy operations are performed on 270,000 men each year making it one of the most frequent operations. Costs of treating this disorder are over $1 billion per year in this country.

Neurogenic Bladder Dysfunction. Disturbances of the neural control of the bladder impair the sensation and the emptying function of the bladder.

Neurogenic bladder dysfunction causes either urinary retention or urinary incontinence. Neurogenic bladders frequently result from birth defects, strokes, multiple sclerosis, Parkinson's disease, spinal cord injury, and diabetes (5-20% of patients).

Male Impotence is a chronic problem affecting between 10 and 35% of the adult male population. Impotence is frequently associated with other medical problems ad diabetes, arteriosclerosis, and neurologic disorders. The economic impact of this problem is not known.

Male Infertility is a major factor in about half of the infertile couples. Approximately 15% of American couples suffer from infertility.

Painful Bladder Disease is a group of poorly understood diseases (interstitial cystitis, urethral syndrome and nonbacterial prostatitis). These patients experience an almost constant desire to void with pain and pressure as the bladder distends. Interstitial cystitis affects an estimated 44,000 to 90,000 patients in the United States with direct and indirect costs estimated at $400 million per year.

Mr. Chairman, we are deeply appreciative to you and your colleagues for requesting in 1988 Appropriation Bill an NIH Study on Research Needs in Urology.

The report language accompanying FY 1988 Appropriation Bill for NIH requested a report on needs in urological research training. A final report will be completed in the Spring of 1989. Preliminary observations are that there is the least number of research trainees studying urologic diseases of any discipline at NIH and the lowest amount of NIH support of any specialty group of diseases.

I want to tell you where the NIH is in carrying out this study. The A.U.A. research leadership has been requested by NIDDK leadership to participate in this study. We very much appreciate the leadership of Dr. Gary Striker, who is Director of Kidney, Urology, and Hematology Division of NIDDK, for his leadership in this matter, and the vigor with which he is carrying out the mandate.

This year the NIDDK funded six George O'Brien Centers at $4 million instead of $6 million required for appropriate levels of activity, and on top of this each center took a 15% cut from peer reviewed approved levels of support.

We recommend doubling the number of O'Brien centers which is based on experiences with other diseases, in particular GI diseases. This would take 6 million new dollars and to fully fund existing ones will take $2.5 million = total 8.5 million in new funding for O'Brien Centers.

For the funded six O'Brien centers, we had 15 applications after only a 3-month announcement lead time to the research community. As a member of the peer review study section, I can attest to the fact that all 15 should have been funded because of their scientific excellence.

Research Training in Urology. There is a documented need to develop research trained urologists and recruit scientists to investigate urologic diseases. The NIDDK now has only two training grants in urology with a total of 3 trainee slots per year. The overall research budget for urology is less than 10% of the division and only 2-3% NIDDK budget. There are 500,000 patients admitted with prostate disease each year at a cost of more than $2 billion in direct costs. Thus, there is clear documentation of need expressed by urology for more training positions to allow immediate efforts to correct the deficit in training.

One mechanisms to accomplish this has already been developed and used in the NIDDK which encourages existing and newly proposed centers to support a new young investigator for up to 100% of time to participate in a training program up to 3 years. In addition, NIDDK allocates a small amount of funds for pilot projects undertaken by trainees. The salary range is up to $70,000 and cost of pilot projects is up to $25,000, so the cost is less than $100,000 per center.

We propose that such trainee awards, if agreed to, would be called George O'Brien Centers Trainee Awards. We propose that 10 of these training mechanisms in the centers be funded. So, number of trainees in urology research would increase from 3 to 13.

Overall, for the NIDDK, we recommend the figure of $680 million which is the recommendation by the Coalition of Voluntary and Professional Organizations interested in NIDDK.

Overall, for the NIH, we recommend a funding level of $8.2 billion, which is the recommendation of the Ad Hoc Coalition for Medical Research.

Thank you, Mr. Chairman, and your colleagues for the excellent support you have given urology research in the past.

Senator INOUYE. As I indicated earlier, although the amount the committee has recommended at this stage is above that suggested by the President, it is still woefully lower than that recommended by the ad hoc group, but we are still in the budgetary process, and the Budget Committee has not reported yet, and we have not really tied down the 302(b) allocation. We still have this important conference with the House.

I am optimistic that we may be able to raise it a bit more. But I should tell you now it will not be too much more.

What you have advised to the committee is very important. It shows that with the appropriation, we can be very cost effective, and we are always concerned about what we call the cost-benefit ratio. It would appear to me, with my little calculator, that for every dollar we invest in your endeavors, we would be saving $1 million? That is a pretty good cost-benefit ratio.

Dr. SHOBE. Yes, sir.

Dr. VAUGHAN. We thank you for your time.

If I could just summarize two major points, the first is there was very strong language from your committee last year in your report for increased funding for diabetes, particularly end-stage renal disease and disease of the lower urinary tract. Since that time, NIDDKD has put out an initiative, they have received very strong response to that; however, there was no additional funding last year to address that response, and therefore, we would very much like to see a new initiative specifically addressing diabetes and end-stage renal disease at the level of $3.7 million for this year.

Second, I would like to reiterate what both Dr. Arant and Dr. Gillenwater said concerning training and the concept that the O'Brien Centers, which are already showing great promise in solving some of these problems, be expanded to incorporate training, and that a very serious look be taken for increased training, particularly in the areas of pediatric nephrology and in urology, which are woefully lacking at this point.

Thank you.

[The statement follows:]

STATEMENT OF E. DARRACOTT VAUGHAN

Thank you for providing the opportunity to comment on the appropriations for the National Institute of Diabetes, Digestive and Kidney Diseases (NIDDKD) for the fiscal year 1989. I am E. Darracott Vaughan, Jr., James J. Colt Professor and Chairman Division of Urology, The New York Hospital-Cornell Medical Center. I appear before you today representing the Intersociety Council on Kidney and Urologic Disease which is made up of virtually all groups active in research and the treatment of kidney and urinary tract disorders with 15,000 physicians and 50,000 lay members.

I follow Dr. Stuart Kleit, Chairman of the newly authorized permanent Kidney and Urological Advisory Board to NIDDKD and you have just heard that the preliminary findings of the Board reveal we have seriously underestimated the impact of kidney and urological diseases on the citizens of this country. Therefore, our Council is seriously worried that at a time when new initiatives are imperative, the budget for the fiscal year 1988 led to a 10 percent cut in RO-1 budgets, both competing and noncompeting, an average 15 percent cut across NIDDKD centers and an actual loss in the total number of new and competing renewal grants to be funded from 686 in 1987 to 572 in 1988. In the area of kidney and urologic diseases, this translates to the loss of 28 grants. Gentlemen, it is obvious that at a time of increasing need, funding is going in the wrong direction.

To be more specific, last year I attempted to emphasize the impact of diabetes on both end stage renal disease and related urological disorders. For example, 85,000 patients with end stage renal disease are on dialysis and more than 7,000 receive transplants annually. Over 40 percent of these patients have diabetes and the percent is increasinng. Diseases of the lower urinary tract cause suffering for some 8 million Americans and incontinence alone costs the country 8 billion dollars in health care costs for the elderly. Diabetic neuropathy often contributes to these problems. In fact, the report of the Senate Appropriations Committee (page 99) reads:

> " The Committee notes with great concern that the largest single cause of renal disease is diabetes mellitus. Expert testimony before the Committee warned that within the next decade the number of patients entering end stage renal disease (ESRD) will increase from 30 percent to 50 percent. ..The Committee therefore, urges the National Institute of Diabetes, Digestive and Kidney Diseases (NIDDK) to undertake new kidney diabetes mellitus research initiatives with the funds provided for fiscal year 1988."

> "While research is advancing rapidly in the area of diabetes, it is becoming increasingly clear that research is needed in the areas where diabetes presents major urological problems. Impotence and neurogenic bladder are diseases often resulting from diabetes, and these areas have had little research in the past. The Committee believes that increased research is needed in this area.".

However, no new money was appropriated for these initiatives. Since that time, a number of new initiatives have been begun in the area of diabetes and renal disease and a recent RFA for approximately 3.7 million dollars has been circulated. However, it is subject to precise funding and this funding directive has not been forthcoming as of this time.

Therefore, we make the recommendation that there be increased funding to NIDDKD for a new diabetes initiative to be no less than 3.7 million dollars for the fiscal year 1989. In addition, we also recommend that further attention be turned to the lower urinary tract both in terms of the diabetic induced bladder and penile dysfunction as well as other abnormalities of the lower urinary tract. In a recent cost analysis study it has been found that a staggering 8 billion dollars a year are spent in the management of patients with urinary incontinence and there has been little attention to this field in the past.

I would next like to address what I feel is a pressing need and that is in training of new investigators particularly in the areas of urology and pediatric nephrology. We need new initiatives to identify and support young investigators in these areas where there is a lack of qualified individuals. Fortunately, funding for training estimated as 100,000/fellow, is not as expensive as funding of research projects and it is also clear that there are identifiable sites of excellence currently present which could support fellowship training with new funds. Therefore, we would make the recommendation that initially the six existing O'Brien centers for kidney and urological disease research which were established by this committee, be expanded and become research and training centers. These fellows would be identified as George O'Brien Trainees.

This initial step of utilizing the O'Brien centers plus identifying other sites of training would subsequently be complemented by the report on needed manpower in urologic research which was requested by the Appropriations Committee last year (Senate report #1100-189, page 101) and the similar statement in the FY-1988 House report as well as studies by the Natinal Kidney and Urologic Diseases Advisory Board concerning manpower needs.

Moreoever, we would like to call to the attention of the Committee that the O'Brien centers were not fully funded when established. Hence, we would recommend an increase to full funding of existing centers to the originally proposed level of 6 million per year or a million/center. Finally, since excellent proposals were approved but not funded we would recommend an increase in numbers of the O'Brien centers to combat the increasing impact of kidney and urologic diseases on the health of our countrymen.

Finally, the Intersociety Council for Research of the Kidney and Urinary Tract supports the recommendation of the Ad Hoc group for the National Institute of Health. Particularly, we urge the subcommittee to fund an overall budget of 8.2 billion dollars for NIH in the fiscal year 1988 including 680 million for NIDDKD.

Senator **Inouye**. Would your panel assist the staff in drafting appropriate report language?

Dr. **Vaughan**. Yes; we would be glad to.

Senator **Inouye**. We are in the process of doing that now, so I will have the staff call upon your people to assist us in the drafting of such language.

Once again, I thank you very much. It has been most enlightening.

The only thing I can say is that my autumn years may not be too pleasant.

Dr. **Vaughan**. We hope to make it more pleasant for you.

Senator **Inouye**. I thank you.

STATEMENT OF CHARLES M. CLARK, JR., M.D., CHAIRMAN, NATIONAL DIABETES ADVISORY BOARD

Senator **Inouye**. Our next witness is the chairman of the National Diabetes Advisory Board, Dr. Charles M. Clark, Jr.

Dr. Clark, I welcome you.

Dr. **Clark**. Thank you.

I could not have had a better introduction. Obviously we agree wholeheartedly with the diabetes end-stage renal disease.

I am Charles Clark, professor of medicine at Indiana University School of Medicine and director of the Diabetes Research and Training Center there and Chairman of the National Diabetes Advisory Board. I am speaking on behalf of the Board.

The Board was established by Congress to review and evaluate implementation of the long-range plan and to report annually to Congress and the Secretary regarding the recommendations. We have just completed a revision of the long-range plan, and we have an annual report and formal testimony which I will submit for the record. I would like for my formal remarks to address some issues I think are of particular importance.

First of all, I think that everybody understands that there are budgetary problems. We have had a tremendous advance in our understanding of the complications of diabetes over the last decade because of research which has been done. Where we are today is at the edge of preventing the complications of diabetes. There are 11 million people with diabetes, 150,000 die every year. But I think in the terms of morbidity, it is the leading cause of blindness. We now have effective treatment, with laser therapy, for blindness. It is a leading cause of new kidney disease. We have effective treatment for kidney disease. It is a leading cause of newborn deaths and congenital defects, but we have treatment for that.

So what we need now, it seems to me, is funding for research to get us to the point of preventing these complications. One very important project, which you have been very supportive of, is the diabetes control and complications trial which is examining the issue of whether or not we can prevent the complications of diabetes, specifically eye complications, by the intensive treatment of diabetes.

Coming down the line are questions about preventing kidney disease by changes in diet or by the treatment of hypertension or perhaps by intensive management of diabetes.

We can prevent the complications of diabetes in pregnancy by intensive management of pregnancy. We need now to move that into the practicing community.

The Board has basically recommended two things: one, an increase in research efforts; and two, an increase in the efforts of the CDC, or the translation of research efforts to practice. The CDC translation center was established last year. We hope that it receives increased funding. We are very happy that that got started.

You talked a lot about training, and I think that we want to also emphasize that training is a problem. If you were to fund the diabetes related training at the NIH at the same level that you funded it in 1980, the same number of people, you would have to double the training budget. That is how far down training has gone. We are short of new people. We are training people from all around the world whose governments are sending them to the best laboratories in the world. We are training them, and they are going back to Japan and they are going back to Europe, and I think that we need to really look at that issue.

A second issue is the centers. We now have diabetes centers, a dozen of them, that are the best in the United States. Many of the advances in research have come from these centers. Last year the centers took a 15-percent cut. It would take an additional $9 million just to fund the centers at the level the peer reviews feel that they could use.

In addition, there are opportunities for new interdisciplinary research in the areas of micromolecular biology and immunology, and we think the establishment of new centers will be just as profitable as continuing the former centers.

PREPARED STATEMENT

I know that you have difficult problems with the budget. I think that over the last decade, since the Diabetes Commission became the advisory board, we have lived up to much of the promise of understanding the pathophysiology and the treatment of the complications of diabetes. I think over the next decade we are looking for methods to prevent these complications from ever occurring.

Thank you very much, and I will be happy to answer any questions you might have.

[The statement follows:]

STATEMENT OF CHARLES M. CLARK, JR.

I am Dr. Charles M. Clark, Jr., Professor of Medicine at Indiana University School of Medicine, Director of the Diabetes Research and Training Center at Indiana University, and Chairman of the National Diabetes Advisory Board (NDAB). The Board was established by Congress to: (1) review and evaluate the implementation of the long-range diabetes plan and (2) report annually to Congress and the Secretary of Health and Human Services on recommendations for future policies, programs, and budgetary requirements related to Federal diabetes research and health care activities.

Diabetes is a major public health problem that has now been diagnosed in about 6 million Americans. An additional 5 million have the disease, but it has not yet been diagnosed; each year, more than 500,000 new cases of diabetes are identified. People afflicted with diabetes face not only a shortened lifespan but also the probability of incurring acute and chronic complications.

- Diabetes accounts for approximately 30 percent of new cases of end-stage renal disease in the United States.
- An estimated 50 percent of all nontraumatic amputations in the United States occur in people with diabetes.
- Heart disease is twice as common and more often fatal in people with diabetes than in the general population.
- Approximately 50 percent of people with diabetes have hypertension compared with about 20 percent of persons without diabetes.
- Babies born to women with diabetes have a threefold increase in the frequency of birth defects, a fivefold increase in other complications that require intensive medical care in the early days of life, and a higher mortality rate than babies born to women without diabetes.
- Detectable loss of nerve function occurs in approximately 40 percent of persons with diabetes; after 25 years of disease, more than 90 percent are affected.

Beyond human suffering, the economic burden of diabetes is tremendous. A conservative estimate of total annual direct costs attributable to diabetes is $13.8 billion. A major portion of these costs is paid by the Federal Government through medicare, medicaid, the Public Health Service, the Veterans Administration (VA) and other Federal health care programs.

Combatting this disease must be a national priority. Fortunately, we have made remarkable progress in our knowledge of the causes, clinical course, and complications of diabetes during the past decade and now have an opportunity to prevent and cure the disease during the next decade. Therefore, Federal funds spent on diabetes activities today can prevent greater Federal spending in future years for patient care. The momentum in diabetes research and its translation to clinical practice must be maintained.

The national long-range plan to combat diabetes, originally developed in 1976, was updated in 1987 to guide the next 10 years of Federal diabetes activities. The plan recommends both continuation and expansion of current programs as well as implementation of major new initiatives. The associated budget recommendations, summarized in table 1, are based upon the estimated level of program activity for fiscal year 1987, which have remained essentially unchanged in fiscal year 1988. The Board urges speedy appropriation of these funds so that the long-range plan may be implemented promptly.

RECOMMENDATIONS FOR NEW FEDERAL RESEARCH AND TRANSLATION PROGRAMS

The National Diabetes Advisory Board recommends:

- Establishment of eight Diabetes Interdisciplinary Research Programs within the NIDDK to promote the integration of new basic science research methodologies and biotechnology into diabetes research programs. Recent developments in these areas have revolutionized approaches to biomedical research resulting in many major advances. Although many of these developments are related to the general field of diabetes and its complications, few investigators trained in these disciplines currently apply their expertise to diabetes research. These interdisciplinary programs will provide direct support for diabetes-related research in basic science laboratories and thereby encourage, in a cost-effective manner, existing facilities at the forefront of biotechnology to attack specific research questions of importance to the diabetes field.
- Establishment of a Diabetes Translation Center (DTC) at the CDC to plan, conduct, and coordinate national efforts to transfer diabetes research more rapidly to patient care. The DTC will have two major

goals: to plan, conduct, coordinate, and evaluate Federal efforts to improve the transfer of diabetes research into patient care and to serve as the focal point for coordination between Federal programs and the private sector.

RECOMMENDATIONS FOR CURRENT FEDERAL RESEARCH PROGRAMS

The National Diabetes Advisory Board recommends:

- Appropriation of adequate funds to the NIDDK to support at least 50 percent of approved competing individual research grants at budget levels approved by the scientific review committees.
- Additional funds be appropriated to the NIDDK to support the diabetes-endocrinology research centers (DERC's) and the diabetes research and training centers (DRTC's) at budget levels recommended by the scientific review committees and to establish four additional DERC/DRTC's.
- Adequate funds be appropriated to the NIDDK and other Institutes of the NIH with diabetes-related programs to support training and development of research personnel in diabetes-related areas at each stage in the educational process. Funding should be restored at least to the fiscal year 1980 level of support. Constraints on NIH intramural manpower training opportunities should be removed.
- The Division of Research Resources receive funds to strengthen the general clinical research centers.
- The National Institute of Child Health and Human Development (NICHD) receive adequate resources to maintain centers that focus on research on pregnancy in women with diabetes.
- The NIDDK receive adequate funds to complete the Diabetes Control and Complications Trial (DCCT) as planned.
- Adequate funds be appropriated to ensure the completion of diabetes-related clinical trials of the NEI and the NICHD.
- Additional funds be appropriated for diabetes prevention and treatment programs in the IHS.
- Additional funds be allocated to the Health Resources and Services Administration (HRSA) for the development of diabetes health care programs and the training of diabetes health care professionals.
- Additional funds be appropriated to the VA to expand diabetes research, training, and health care delivery programs.

- Additional funds be appropriated to the National Center for Health Services Research (NCHSR) to conduct diabetes-related research projects and train manpower in diabetes health services research.
- Additional funds be appropriated for support of Board activities and that a full-time executive director be assigned to assist the Board.

Thank you for the privilege of appearing before your subcommittee. I will be pleased to respond to any questions you may have.

Table 1
Budget Recommendations for Diabetes-Related Programs[a]
(Millions of Dollars)

	1987 Est. Appropriations	Long-Range Plan Additions
National Institutes of Health (NIH)		
National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)		
Diabetes Interdisciplinary Research Programs	—	10.0
Biologic Resource Bank	—	[b]
Information and Data System	—	[b]
Research Project Grants	82.4	23.4
Training and Development of Research Personnel	6.4	5.7
Diabetes Endocrinology Research Centers/Diabetes Research and Training Centers	13.5	9.0
Other Diabetes Programs	19.0	—
Subtotal, NIDDK	121.3	48.1
National Heart, Lung, and Blood Institute	14.8	5.2
National Eye Institute	21.3	5.7
National Institute of Child Health and Human Development	12.5	3.3
National Institute on Aging	2.6	0.7
National Institute of Allergy and Infectious Diseases	7.2	1.8
National Institute of Dental Research	4.5	1.3
National Institute of General Medical Sciences	2.5	0.7
National Institute of Neurological and Communicative Disorders and Stroke	8.5	2.2[c]
Division of Research Resources	16.1	9.0[d]
National Center for Nursing Research	1.1	0.3
Other	0.6	0.2
Subtotal, NIH	213.0	78.5
Centers for Disease Control		
Diabetes Translation Center	7.2[e]	14.0
Indian Health Service		
Diabetes Treatment and Prevention Program	2.9	5.0
Health Resources and Services Administration	—	3.5
National Center for Health Services Research	—	1.7
Veterans Administration	[f]	3.5

[a] Amounts are for diabetes-related activities within these agencies.

[b] Required resources to be determined upon completion of project plans.

[c] Additional resources to be determined upon completion of NIH plan to increase research activity in diabetic peripheral neuropathy.

[d] Includes $7.5 million for General Clinical Research Centers Program and $1.5 million for Clinical Associate Physician Program.

[e] Current budget of the Centers for Disease Controls' diabetes control program, to be incorporated into the new Diabetes Translation Center.

[f] Amount not available.

Senator **Inouye**. I am certain you are not aware of this, but I am presently chairman of the Select Committee on Indian Affairs, and for many reasons Indians are now experiencing worse statistics in health. In the area of diabetes it appears that when an American Indian reaches the age of 50, chances are he will have diabetes because over 50 percent of those men and women are diabetic.

Why is it so high among Indians?

Dr. **Clark**. In the last 2 days there was an NIH conference on diabetes and Hispanics.

Diabetes is an equal opportunity disease. Native Americans, Hispanics and blacks all have an increased incidence, but none of it approaches the 40 percent among the American Indians; for instance, the Pima Indians in the Southwest. The NIH has supported, for a number of years, a research center in Phoenix examining these issues. I hope that this will not only help the Indians, but also help all people with diabetes by getting an understanding.

In the Pima Indians, and probably in diabetes in general, at least adult diabetes, there clearly is a gene or a group of genes at fault. This gene must have had some benefit in primitive times when food was not available. But in Western society, when you become westernized, diabetes becomes very common. It is interesting that Indian Indians, when they move, and become middle class in Africa and in England, also have a very high rate of diabetes. When Japanese, who have a very, very low rate of diabetes, move to Hawaii and the United States, the rate of diabetes goes up. There is clearly something genetic here, and there is clearly something which causes this gene to be expressed in the environment.

We know, for example, in the Pima Indians, that they are much heavier than they used to be, and the incidence of diabetes has gone from about 20 to 25 percent 10 years ago, to almost 50 percent today.

I am very pleased in the support for this program and the demonstration programs in the Indian Health Service, which moves treatment to the Indians. We don't know the answer, but we are getting closer.

It is clearly something genetic. You can clearly see a difference in the Indians who are going to develop diabetes well before they develop diabetes in their ability to handle carbohydrates and sugar.

Senator **Inouye**. Well, I thank you very much, Doctor. It has been very helpful.

STATEMENT OF DR. PAULA HARBISON, INTERSTITIAL CYSTITIS ASSOCIATION

Senator **Inouye**. Our next witness represents the Interstitial Cystitis Association, Ms. Paula Harbison.

Dr. **Harbison**. Honorable Chairman, good morning. Thank you for allowing the Interstitial Cystitis Association [ICA] to represent our concerns to you today. Through your support over the last 2 years we have made significant strides toward our goal of finding a cure for interstitial cystitis [IC], and although much more needs to be done, your committee's interest and support is truly appreciated by all IC patients and their families.

I am Paula Harbison. I am a podiatrist practicing in Los Angeles, CA. I am chairperson of the Interstitial Cystitis Association of America, and I have interstitial cystitis.

The ICA was founded 4 years ago. Since then we have established a nationwide support system to serve the victims of interstitial cystitis. This year we received excellent media coverage, appearing in the Washington Post and U.S. News & World Report. We are a member of the National Organization for Rare Disorders. Our medical advisory board includes some of the top urologists in this country.

Interstitial cystitis is a chronic inflammatory disease affecting the lining of the urinary bladder. Intense and excruciating pain, accompanied by urinary frequency of as much as 60 times per day are its symptoms. The cause of interstitial cystitis is unknown, as is the cure.

A recent epidemiological study conducted by the ICA in cooperation with the Urban Institute and NIDDK found that 450,000 people in the United States may suffer from interstitial cystitis. Of these, 50 percent are unable to work because of the pain and disability caused by this disease. The life satisfaction rating for IC patients was found to be lower than that for renal failure patients on chronic dialysis.

When lost wages incurred through IC are combined with medical treatment expenses, this study showed a national economic impact of $1.7 billion per year. I am here to appeal to you to continue your support for IC research. We feel that it is imperative that IC research be solicited and supported by the National Institutes of Health. Last year's funding of proposals at the University of Pennsylvania and the University of California, San Diego, were an encouraging beginning, but in order to be able to fund high quality proposals, it is necessary to solicit them through the request for applications process, not just 1 year, but each year until a larger research community is established.

It is also crucial to fund research proposals specifically related to IC. Although research proposals on general areas of bladder physiology are certainly commendable, it is now time to concentrate on specific areas of inquiry regarding interstitial cystitis. To assist in this, and to allow gathering of essential data, we urge you to support the Federal funding of a national interstitial cystitis registry. The registry would allow statistics gathered through epidemiological studies to be analyzed, updated, and used as a research base.

Last year your committee strongly encouraged the allocation of supplementary funds to conduct basic research on interstitial cystitis at the established kidney and urological diseases research centers. The NIDDK chose not to set up such a program, nor do they have plans to do so in the future. The lack of such a program can only serve to further remove us from our goal of finding a cure for IC.

We therefore request the following: one, that interstitial cystitis be included in the Senate committee report, and that specific funding be allocated for new IC research proposals; two, that a request for application be issued in 1988 and 1989 specifically directed at IC research; three, that funding be earmarked for the establishment of a national interstitial cystitis registry; and four, that IC research centers be established to conduct both basic and clinical research.

PREPARED STATEMENT

Our need is great, but we are confident that with your support and adequate funding for IC research through NIDDK, a cure for IC will be found.

I know what it is like to live with constant, unremitting pain. I thank you for allowing us to speak with you today.

[The statement follows:]

STATEMENT OF DR. PAULA HARBISON

Thank you for allowing the Interstitial Cystitis Association to represent our concerns to you today. Through your support over the last two years we have made significant strides in our goal of finding a cure for interstitial cystitis. We are very grateful for the federal funding of two IC research projects in FY 1987 and for the Medical Workshop on IC sponsored by NIDDK last fall. Although much more needs to be done, your committee's interest and support is truly appreciated by all IC patients, and their families.

I am Paula Harbison, a podiatrist and I practice in Los Angeles, California. I also have interstitial cystitis and I serve as Chairperson of the Interstitial Cystitis Association. The ICA was founded four years ago and since then we have established nation-wide support systems to serve the victims of IC. This year we received excellent media coverage appearing in numerous newspapers including The Washington Post and magazines such a U.S. News and World Report. We are a member of the National Organization of Rare Disorders (NORD) and our Medical Advisory Board includes the top urologists in the country. Since I addressed you last year, the ICA in cooperation with the Urban Institute and the NIDDK has completed the first large scale Epidemiological Study on interstitial cystitis. The analysis of its data has uncovered some important, yet alarming statistics on the disease.

Interstitial cystitis is a bladder disease which is too frequently ignored by the medical profession. It is an inflammatory disease affecting the bladder wall. Intense and progressive inflammation lead to deep scarring and contracture of the walls of the bladder. The result in the patient is an intense, unrelenting, excruciating pain accompanied by the constant need to urinate. The frequency of urination can be as much as 60 times a day. As a result of the pain and frequency many IC patients become totally housebound unable to work or engage in ordinary activity.

The Study found that 450,000 people in the U.S. may suffer with IC and of those patients 50% are unable to work full time compared to that of the general population. For those who do work -- they receive $3.41 an hour less than those without the disease with the same education and qualification. This means that those who can work are forced to take jobs below their training and ability because of the disease. By combining the additional medical expenses incurred by an IC patient with the lost wages because of the disability, the Study calculated the economic impact of the disease to be as high as 1.7 billion dollars per annum.

The Study also revealed that it took an IC patients an average of 4 1/4 years and 5 doctors to achieve a correct diagnosis of their condition. The Study found that in the U.S. there are at least 5 IC patients who remain undiagnosed for every 1 who is. This journey towards diagnosis can be frustrating and painful. Unfortunately, urologists still have difficulty recognizing this condition due largely to their early medical training and its lack of emphasis on IC. This is a disease which mainly affects women -- the median age of onset being 40 years of age with 25% under the age of 30.

The affect of IC on a young woman's life can be devastating. In addition to the unrelenting pain and frequent urination -- 63% of the IC patient population experience pain with intercourse -- with many being unable to have intercourse at all! This disease can cause profound damage to every aspect of an IC patient's life from one's career to one's marriage including one's childbearing and rearing ability. Suicide is a very serious problem within the IC patient population. The Study found that IC patients have suicide thoughts 3-4 times that of the general population. Their life satisfaction rating was much lower than that of the general population and was even lower than the average rating given by white female kidney dialysis patients! Many of these victims cannot even leave their homes for a short trip to the grocery store. They are trapped in a body that is torturing them day and night, with no hope of relief. There is no cure for interstitial cystitis and one quarter of IC patients receive no relief from any individual treatment.

I am here to appeal to you to continue your strong support for IC research. In your Report last year you stressed your belief that "the Institute should continue to solicit research proposals on the etiology and treatment of interstitial cystitis and should give such proposals high priority, special consideration, and support." Unfortunately, the NIDDK did not issue a Request for Applications in FY 1987 and, it is our understanding that no specific proposals on IC were funded in response to the RFA issued in FY 1986. And, although your committee strongly encouraged "the allocation of supplementary funds to conduct basic research on interstitial cystitis at the established kidney and urologic diseases research centers", the NIDDK chose not to set up such a program in those centers, nor do they have plans to do so in the future.

In order to find a cure for interstitial cystitis -- we need to know more about the disease and how it manifests itself over time and throughout the IC patient population. It is for this reason that we urge you to support the federal funding of a National Registry. This Registry would allow the statistics gathered in the large scale epidemiological study to be further analyzed and updated and for new statistics to be collected in one central location. The analysis of such statistics would enable us to discover the etiology of IC and move us closer and faster towards an effective treatment and cure for IC.

In addition to a National Registry which will help us develop a better understanding of the disease, it is imperative that IC research be solicited and supported at the National Institutes of Health. Last year's funding for IC research at the University of Pennsylvania and at the University of California-San Diego was an encouraging beginning, but will not alone answer all of the outstanding questions about a disease like IC with no known etiology or cure. In order to be able to fund high quality proposals it is necessary to solicit them through a Request for Application process not just one year, but each year until a larger research community is established. It is also crucial to then fund research proposals specifically related to IC that are submitted in response to the RFAs. While research projects on more general areas of bladder physiology will contribute to a better overall understanding of the bladder's function -- it is now time to start zeroing in on specific areas of inquiry - like the functioning of the female bladder and why it becomes diseased with interstitial cystitis. Time is running out for many young women and also men who are only beginning their careers and starting families. The older IC patient is forced to take early retirement -- a retirement filled with pain and suffering. Their lives depend on IC research and your support in funding them at the federal level.

We therefore REQUEST THE FOLLOWING:

(1) that interstitial cystitis be included in the Senate Committee Report and that specific funds be allocated or earmarked for the funding of new IC research proposals;

(2) that a Request For Application be issued in 1988 and 1989 specifically directed at IC research;

(3) that funding be earmarked for the establishment of a National Registry on IC; and

(4) that IC Research Centers be established to conduct both clinical and basic research.

Our need is great. But we are confident that with your help and with adequate funding for IC research through NIDDK, the results will be no less than miraculous. As a victim of IC, I know what it is like to endure chronic unrelenting pain. I represent those who are too ill to leave their homes, and who cannot be here with us today. Please help us to end our suffering. Help us find a cure for IC. Thank you.

Senator INOUYE. Thank you for your most compelling testimony. What is the current method of treatment?

Dr. HARBISON. There is no universally satisfactory treatment for interstitial cystitis. The only cure is bladder removal with the use of an ostomy or an opening on the side of the abdominal wall for drainage of the urine. There are some treatments which are used, including dimethyl sulfoxide, or DMSO. It is the only medically recognized use for DMSO, by the way. It is effective in approximately 50 percent of new patients. However, this drops off as the drug is used more and more. Eventually it becomes much less effective. There is no other effective treatment.

Senator INOUYE. And how do you get this cystitis?

Dr. HARBISON. We don't know.

Senator INOUYE. Well, looking over your request, I can tell you now of the inclusion of language in our committee report, I am certain my colleagues will go along with that.

As to a request for application issued in 1988 and 1989, specifically directed at IC research, we will assist you in getting that.

As to the last two, the funding earmarking for the establishment of a national registry, can you provide us with a memo on that because I don't think we know enough about this.

Dr. HARBISON. Certainly, we would be glad to.

Senator INOUYE. And as to what, if any, costs are involved——

Dr. HARBISON. Certainly.

Senator INOUYE. And on the final recommendation, the establishment of IC research centers, if you can also provide us with a memo as to what is involved, how much is involved.

Dr. HARBISON. Certainly. That was in the committee language last year.

Senator INOUYE. Well, I did not realize that it was that bad, but I presume from your testimony, although you did not say so specifically, that this cystitis affects women more than men?

Dr. HARBISON. Yes; 1 out of 10 patients is male. It is primarily a female condition. However, it does affect males and children as well. We are finding more and more children now being diagnosed. Before it was considered only to be a disease of postmenopausal women, but the problem was that it has been misdiagnosed. It has been thought to be that kind of a disease for so long that urologists were not looking for it in children or in men. Now that they are becoming more aware of it, in part through our efforts and also NIDDK, they are finding more and more cases in children and in men.

Senator INOUYE. Can you also provide us with a memo on certain specifics? You did not give this in your oral testimony, but in your prepared statement you speak of suicides.

Can you give us numbers on that?

Dr. HARBISON. Yes; the Urban Institute study found that compared to general population, interstitial cystitis victims consider suicide seriously four times more often.

Senator INOUYE. Four times——

Dr. HARBISON. Four times more often than the general population.

Senator INOUYE. Well, you have convinced me. I will do my best.

Dr. HARBISON. Thank you, sir.

STATEMENT OF ALAN D. CHERRINGTON, M.D., AMERICAN DIABETES ASSOCIATION, INC.

Senator **Inouye**. Our final witness is Dr. Alan D. Cherrington, representing the American Diabetes Association.

Dr. Cherrington, welcome, sir.

Dr. **Cherrington**. Thank you.

Mr. Chairman, I am Dr Alan D. Cherrington, vice president of the American Diabetes Association [ADA]. I also serve as professor of molecular physiology and biophysics and of medicine and as associate director of the Diabetes Center at Vanderbilt University in Nashville.

I would like to summarize my prepared statement and ask that my full statement be included in the hearings record.

Senator **Inouye**. Without objection, so ordered.

Dr. **Cherrington**. Thank you.

The American Diabetes Association represents the interests of over 11 million Americans with diabetes. As you have already heard, diabetes is the cause of many complications which result in great health care costs, and what I would really like to do is to try and amplify that.

Some recent studies indicate that the yearly cost of diabetes may now be as high as $23 billion per year. There are a variety of studies, some attest to the fact that it may be $17 billion, some $23 billion, the point being that there is a very high dollar cost associated with the care of diabetics who have a variety of these complications.

Senator **Inouye**. That is the cost of care?

Dr. **Cherrington**. That is the cost of care.

Diabetes is the leading cause of new blindness in this country; 40 to 60 percent of leg amputations for nontraumatic causes are due to diabetes.

Senator **Inouye**. But this does not include the loss of earnings.

Dr. **Cherrington**. As far as I know, no.

The generous and unwavering support provided by you and your colleagues on this subcommittee has resulted in many of the gains which have been made in diabetes research. The research programs of the NIH and the CDC are in large part responsible for the tremendous strides we have made in recent years in diagnosing and treating this terrible disease. For example, a promising avenue of investigation is transplantation of the insulin producing islet cells from the pancreas. This process offers several advantages over transplantation of the entire pancreas which remains a difficult and somewhat risky procedure. However, further research is required to determine effective methods to prevent rejection of transplanted islet cells by the body's immune system.

Diabetes researchers now agree that a major factor in the development of insulin dependent diabetes is a breakdown in the body's immune system. In defending against a viral infection, for example, the body's autoimmune system may damage or destroy the insulin producing cells within the pancreas. Scientists are now exploring the use of immunosuppressive drugs to combat this problem.

The diabetes control and complications trial is a critically important 12-year initiative supported by the NIDDK designed to assess whether strict control over the blood glucose level can lessen or help avoid the severe complications associated with the disease.

The outcome of the trial should allow improvement in the therapy for treating type I diabetes which will result in a savings of billions of dollars in health care costs as a result of a decrease in these complications.

Recent research advances in diabetes have already had a tremendous impact on our economy. For example, two clinical trials have shown that development of laser therapy to treat diabetic eye disease has resulted in an annual cost savings of $250 to $300 million. However, despite these advances and breakthroughs, the pressing health needs of this Nation's diabetic community still have not been met.

To meet these needs, the American Diabetes Association wishes to submit the following proposals for the fiscal year 1989. First, we vigorously support the recommendation of the ad hoc group for medical research funding for a fiscal year 1989 appropriation of $8.221 billion for the NIH. The ad hoc group proposal would provide approximately 7,450 new and competing research project grants at a 41-percent award rate. The proposal would provide approximately the same program balance at NIH as is supported under the current appropriation.

Second, for the NIDDK, we recommend a fiscal year 1989 appropriation of $680.5 million, a figure supported by the NIDDK coalition. The coalition recommendation would provide for 752 new and competing research project grants and support 50 centers, an increase of 10 above the current number, at full cost.

Further, we advocate increased funding for clinical trials at the NIDDK and other Institutes which have played a critical role in diabetes research and treatment.

Third, the CDC's diabetes control program is conducting demonstration projects to develop and test strategies to address the complications related to diabetes. For these activities, the ADA recommends an appropriation of $14 million for enhancement of CDC initiatives that translate basic research into clinical practice.

PREPARED STATEMENT

Mr. Chairman, we trust Congress will continue to make the difficult fiscal choices that are necessary to ensure the strength of the economy while providing a Federal budget that begins to meet the urgent health needs of America's 11 million people with diabetes.

Thank you.

[The statement follows:]

STATEMENT OF ALAN D. CHERRINGTON

Mr. Chairman, I am Alan D. Cherrington, Ph.D., Vice President of the American Diabetes Association (ADA). The ADA represents the interests of over 11 million Americans with diabetes, and is comprised of 55 state affiliate associations, over 800 chapters, and over 225,000 lay and professional members.

Diabetes is a disease in which the body does not produce or properly respond to insulin, a hormone required to regulate blood glucose levels. The cost of diabetes to our society in human and economic terms is staggering. Diabetes is one of the leading causes of death in this country. It is the leading cause of new blindness in the United States, and is a major contributing factor in the development of heart attacks, kidney failure, and nerve disease. Recent studies currently under review by the American Diabetes Association indicate that the cost of diabetes may have increased to as high as $23 billion.

We are on the threshold of an exciting new era in diabetes research--an era that holds the promise of a possible cure, and certainly effective new treatments, for diabetes. The research programs of the National Institutes of Health (NIH), the Centers for Disease Control (CDC) and other Federal centers for medical research are in large part responsible for the tremendous strides we have made in recent years in diagnosing and treating this terrible disease.

Our success in improving the health and well-being of people with diabetes and in exploring alternatives for a possible cure can be attributed directly to the generous and unwavering support provided by you, Mr. Chairman, and the other members of this Subcommittee.

There are now exciting new research advances and opportunities on the horizon that hold the potential for curing or significantly improving the health and well-being of people with diabetes--opportunities that can be fully explored only through adequate Federal funding of diabetes research. Some of these opportunities include:

Islet Cell Transplantation. Transplantation of the insulin-producing islet cells from the pancreas offers several advantages over transplantation of a whole pancreas, which remains a difficult and risky procedure.

A particularly promising avenue of investigation is the use of fetal islet cells in transplantation; in some cases fetal islet cells can grow and adapt to the body's insulin requirements to control blood glucose levels. However, further research is required to determine effective methods to prevent rejection of fetal, as well as adult, cells by the body's immune system.

The Autoimmune System. Diabetes researchers now agree that a major factor in the development of insulin-dependent diabetes is a breakdown in the body's immune system. For reasons that are not yet entirely clear, in response to a viral infection or other triggering mechnism the body's autoimmune system may damage or destroy the insulin-producing cells within the pancreas. Promising clinical trials are now underway to assess the effectiveness of the use of cyclosporin-A, an immunosuppressive drug, immediately after diagnosis of diabetes to halt further attack on pancreatic islet cells from the autoimmune system.

The Diabetes Control and Complications Trial (DCCT). The DCCT is a twelve-year clinical trial designed to assess whether strict control over blood glucose levels can lessen or help avoid the severe complications of diabetes. This is a critical question to answer in treating Type I diabetes. The DCCT, which is supported by the National Institute of Diabetes, Digestive, and Kidney Diseases (NIDDK), is approaching the halfway point and is now being conducted in 27 medical centers throughout the United

States. If, as is predicted, the trial yields positive results, the current therapy for treating Type I diabetes will be greatly intensified.

The evidence is clear that research advances in diabetes have had a tremendous impact on our economy as well as on the health of America's citizens. For example, the development of laser therapy to treat diabetic retinopathy and maculopathy--degenerative eye conditions that if left untreated can result in blindness or severe loss of vision--has resulted in annual cost savings of $250-$300 million. These findings have come from two large collaborative trials supported by the National Eye Institute--the Diabetic Retinopathy Study (DRS) and the Early Treatment Diabetic Retinopathy Study (ETDRS).

However, despite the advances and breakthroughs medical research has provided in the treatment of diabetes, and despite the impressive historical support Congress has provided for the NIH and NIDDK, the pressing health needs of this nation's diabetes community still have not been met.

To help address this disparity and begin to more adequately meet the urgent health research and health care needs of people with diabetes, the ADA wishes to submit the following proposals for FY 1989.

AMERICAN DIABETES ASSOCIATION (ADA) RECOMMENDATION

National Institutes of Health (NIH)

The ADA plays a leadership role in the Ad Hoc Group for Medical Research Funding, a coalition of over 125 voluntary health agencies, professional and academic societies, and research institutions that annually develops a budget counterproposal for NIH and ADAMHA. We vigorously support the Ad Hoc Group's recommendation for FY 1989 of an appropriation of $8.221 billion for NIH.

For the NIDDK, we recommend an FY 1989 appropriation of $680.5 million--a figure supported by the NIDDK Coalition, a group of over 40 voluntary health agencies and professional and academic societies. The NIDDK Coalition recommendation would provide for a 44 percent award rate for new and competing research project grants funded by NIDDK and provide support for 50 centers--an increase of 10 above the current number--at full cost.

Centers for Disease Control (CDC)

The CDC's Diabetes Control Program, in conjunction with 30 state Departments of Health, is conducting demonstration projects to develop and test strategies to address the complications related to diabetes, including diabetic retinopathy, diabetic neuropathy, and end-stage renal disease.

For these activities, the ADA recommends an appropriation of $14 million for enhancement of CDC diabetes translation initiatives.

Mr. Chairman, we recognize that the effort to reduce the Federal budget deficit is one of Congress' and the nation's top priorities. However, the economic impacts of diabetes in America and the effects the disease has on its victims are two compelling reasons to provide increased funding for diabetes research. We trust Congress will continue to make the difficult fiscal choices that are necessary to ensure the strength of the economy while providing a Federal budget that begins to meet the urgent health needs of America's 11 million people with diabetes.

Senator INOUYE. Thank you very much, Doctor.

As I indicated earlier, although the amount that we have in the books at this time is more than the President's recommendation, it will not approximate that recommended by the ad hoc group, but we are still in the budgetary process, and we have not reached the final numbers. We hope that as we move along we will continue to increase our recommendations.

This morning has been a most enlightening one. My only regret is that all of my colleagues were not here to hear all of the witnesses, especially those Members of the Senate who have reached the age of 50 and above. I think they would be scampering to support all of you here.

But I will do my best to share with my colleagues the testimony of all of you who have participated this morning.

Can you provide us with, in addition to the estimate of $23 billion, the cost of treatment part of your testimony.

Dr. CHERRINGTON. That is my belief. I can have the ADA staff determine that.

Senator INOUYE. If you could also provide us with the estimated cost of loss of wages, et cetera, brought about by diabetes, it might be a bit more compelling.

Dr. CHERRINGTON. Thank you. I will do that.

Senator INOUYE. Thank you for waiting all these hours to be with us. Thank you for your testimony, sir.

Dr. CHERRINGTON. Thank you.

SUBCOMMITTEE RECESS

Senator INOUYE. This subcommittee will stand in recess until 9:30 a.m. Thursday, May 26, when we will continue to receive testimony from public witnesses.

[Whereupon, at 11:43 a.m., Wednesday, May 25, the subcommittee was recessed, to reconvene at 9:30 a.m., Thursday, May 26.]

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